FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	FI Outpatient Claim Record - Encrypted Standard View	REC	VAR			Fiscal intermediary Outpatient Encrypted Standard View for version I of the NCH. The Encrypted Standard View supports the users of CMS data and provides the data in "text" ready format for easy conversion to ASCII text files. This file is also specifically processed to perform CMS standard encryption processes for identifiable and personal health information data fields.
****	FI Outpatient Claim Fixed Group - Encrypted Standard View	GROUP	279	1	279	Fixed portion of the fiscal intermediary claim record for the Encrypted Standard View of the Outpatient version I NCH Nearline File.
1.	Record Length Count	NUM	5	1	5	The length of the claim record. 5 DIGITS UNSIGNED
2.	Record Number	NUM	9	6	14	A sequentially assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim.
3.	Record Type	NUM	2	15	16	Type of Record. CODES: 00 = Fixed/Main Group 01 = Carrier Line Group 02 = Claim Demonstration ID Group 03 = Claim Diagnosis Group 04 = Claim Health PlanID Group 05 = Claim Occurrence Span Group 06 = Claim Procedure Group 07 = Claim Related Condition Group 08 = Claim Related Occurrence Group 09 = Claim Value Group 10 = MCO Period Group 11 = NCH Edit Group 12 = NCH Patch Group 13 = DMERC Line Group 14 = Revenue Center Group
4.	Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim.
5.	NCH Claim Type Code	CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH. NOTE1: During the Version H conversion this field was populated with data through-out history (back to

service year 1991).

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.

DB2 ALIAS: NCH_CLM_TYPE_CD
SAS ALIAS: CLM_TYPE
STANDARD ALIAS: UTLOUTPI_NCH_CLM_TYPE_CD
SYSTEM ALIAS: LTTYPE
TITLE ALIAS: CLAIM_TYPE

DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
  NCH CLM_NEAR_LINE_RIC_CD
  NCH PMT_EDIT_RIC_CD
  NCH CLM_TRANS_CD
  NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (Pre-HDC processing -- AVAILABLE IN NCH)
  CLM_MCO_PD_SW
  CLM_RLT_COND_CD
  MCO_CNTRCT_NUM
  MCO_OPTN_CD
  MCO_PRD_EFCTV_DT
  MCO_PRD_TRMNTN_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (HDC processing -- AVAILABLE IN NMUD)
  FI_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD)
  FI_NUM
  CLM_FAC_TYPE_CD
  CLM_SRVC_CLSFCTN_TYPE_CD
  CLM_FREQ_CD
NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)
  CARR_NUM
  CLM_DEMO_ID_NUM
OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)
  FI_NUM

FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM

CLM_FAC_TYPE_CD
CLM_SRVC_CLSFCTN_TYPE_CD
CLM_FREQ_CD

DERIVATION RULES:

SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
2. PMT_EDIT_RIC_CD EQUAL 'F'
3. CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
CLSFCTN_TYPE_CD = '2', '3' OR '4' &
CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one or
more line item(s) match the HCPCS on the
DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CARR_NUM = 80882 AND 2. CLM_DEMO_ID_NUM = 38 SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
					1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD not on DMEPOS table SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).
					CODES: REFER TO: NCH_CLM_TYPE_TB IN THE CODES APPENDIX SOURCE: NCH
6. Beneficiary Birth Date	NUM	8	22	29	The beneficiary's date of birth. For the ENCRYPTED Standard View of the Outpatient files, the beneficiary's date of birth (age) is coded as a range. 8 DIGITS UNSIGNED DB2 ALIAS: BENE_BIRTH_DT SAS ALIAS: BENE_DOB STANDARD ALIAS: BENE_BIRTH_DT TITLE ALIAS: BENE_BIRTH_DATE EDIT-RULES FOR ENCRYPTED DATA: 0000000R WHERE R HAS ONE OF THE FOLLOWING VALUES. 0 = Unknown 1 = <65 2 = 65 Thru 69 3 = 70 Thru 74 4 = 75 Thru 79 5 = 80 Thru 84 6 = >84 SOURCE: CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
7.	Beneficiary Identification Code	CHAR	2	30	31	The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary. COMMON ALIAS: BIC DA3 ALIAS: BENE_IDENT_CODE DB2 ALIAS: BENE_IDENT_CD SAS ALIAS: BIC STANDARD ALIAS: BENE_IDENT_CD TITLE ALIAS: BIC EDIT-RULES: EDB REQUIRED FIELD CODES: REFER TO: BENE_IDENT_TB IN THE CODES APPENDIX SOURCE: SSA/RRB
8.	Beneficiary Race Code	CHAR	1	32	32	The race of a beneficiary. DA3 ALIAS: RACE_CODE DB2 ALIAS: BENE_RACE_CD SAS ALIAS: RACE STANDARD ALIAS: BENE_RACE_CD SYSTEM ALIAS: LTRACE TITLE ALIAS: RACE_CD CODES: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = North American Native SOURCE: SSA
9.	Beneficiary Residence SSA Standard County Code	CHAR	3	33	35	The SSA standard county code of a beneficiary's residence. DA3 ALIAS: SSA_STANDARD_COUNTY_CODE DB2 ALIAS: BENE_SSA_CNTY_CD SAS ALIAS: CNTY_CD STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD TITLE ALIAS: BENE_COUNTY_CD

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						EDIT-RULES: OPTIONAL: MAY BE BLANK SOURCE: SSA/EDB
10.	Beneficiary Residence SSA Standard State Code	CHAR	2	36	37	The SSA standard state code of a beneficiary's residence. DA3 ALIAS: SSA_STANDARD_STATE_CODE DB2 ALIAS: BENE_SSA_STATE_CD SAS ALIAS: STATE_CD STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD TITLE ALIAS: BENE_STATE_CD EDIT-RULES: OPTIONAL: MAY BE BLANK CODES: REFER TO: GEO_SSA_STATE_TB IN THE CODES APPENDIX COMMENT: 1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement. 2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish. 3. Also used for special studies. SOURCE: SSA/EDB
11.	Beneficiary Sex Identification Code	CHAR	1	38	38	The sex of a beneficiary. COMMON ALIAS: SEX_CD DA3 ALIAS: SEX_CODE DB2 ALIAS: BENE_SEX_IDENT_CD SAS ALIAS: SEX STANDARD ALIAS: BENE_SEX_IDENT_CD SYSTEM ALIAS: LTSEX TITLE ALIAS: SEX_CD EDIT-RULES: REQUIRED FIELD CODES: 1 = Male 2 = Female 0 = Unknown

SOURCE:
SSA,RRB,EDB

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
12.	Claim Attending Physician UPIN Number	CHAR	6	39	44	On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected to certify and recertify the medical necessity of

the services rendered and/or who has primary responsibility for the beneficiary's medical care and treatment (attending physician).

This field is ENCRYPTED for the ENCRYPTED Standard View of the Outpatient files.

COMMON ALIAS: ATTENDING_PHYSICIAN_UPIN
DB2 ALIAS: ATNDG_UPIN
SAS ALIAS: AT_UPIN
STANDARD ALIAS: CLM_ATNDG_PHYSN_UPIN_NUM
TITLE ALIAS: ATTENDING_PHYSICIAN

COMMENT:
Prior to Version H this field was named: CLM_PRMRY_CARE_PHYSN_IDENT_NUM and contained 10 positions (6-position UPIN and 4-position physician surname).

SOURCE:
CWF

13.	Claim Diagnosis E Code	CHAR	5	45	49	Effective with Version H, the ICD-9-CM code used to identify the external cause of injury, poisoning, or other adverse affect. Redundantly this field is also stored as the last occurrence of the diagnosis trailer.

NOTE: During the Version H conversion, the data in the last occurrence of the diagnosis trailer was used to populate history.

DB2 ALIAS: CLM_DGNS_E_CD
SAS ALIAS: DGNS_E
STANDARD ALIAS: CLM_DGNS_E_CD
TITLE ALIAS: DGNS_E_CD

SOURCE:
CWF

14.	Claim Excepted/Nonexcepted Medical Treatment Code	CHAR	1	50	50	Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a

Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is required under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.

DB2 ALIAS: EXCPTD_NEXCPTD_CD
SAS ALIAS: TRTMT_CD
STANDARD ALIAS: CLM_EXCPTD_NEXCPTD_TRTMT_CD
TITLE ALIAS: EXCPTD_NEXCPTD_CD

1 FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					CODES: 0 = No Entry 1 = Excepted 2 = Nonexcepted SOURCE: CWF
15. Claim Facility Type Code	CHAR	1	51	51	The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility that provided care to the beneficiary. COMMON ALIAS: TOB1 DB2 ALIAS: CLM_FAC_TYPE_CD SAS ALIAS: FAC_TYPE STANDARD ALIAS: CLM_FAC_TYPE_CD TITLE ALIAS: TOB1 CODES: REFER TO: CLM_FAC_TYPE_TB IN THE CODES APPENDIX SOURCE: CWF
16. Claim Frequency Code	CHAR	1	52	52	The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care. COMMON ALIAS: TOB3 DB2 ALIAS: CLM_FREQ_CD SAS ALIAS: FREQ_CD STANDARD ALIAS: CLM_FREQ_CD SYSTEM ALIAS: LTFREQ TITLE ALIAS: FREQUENCY_CD CODES: REFER TO: CLM_FREQ_TB IN THE CODES APPENDIX SOURCE:

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						CWF
***	Claim Locator Number Group	GROUP	11	53	63	This number uniquely identifies the beneficiary in the NCH Nearline. STANDARD ALIAS: CLM_LCTR_NUM_GRP
17.	Beneficiary Claim Account Number	CHAR	9	53	61	The first nine characters identify the primary beneficiary under the SSA or RRB programs submitted. This field is ENCRYPTED for the ENCRYPTED Standard View of the Outpatient files. STANDARD ALIAS: BENE_CLM_ACNT_NUM LIMITATIONS: RRB-issued numbers contain an overpunch in the first position that may appear as a plus zero or A-G. RRB-formatted numbers may cause matching problems on non-IBM machines.
18.	NCH Category Equatable Beneficiary Identification Code	CHAR	2	62	63	These two characters are the code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner. The equatable BIC module electronically matches two records that contain different BICs where it is apparent that both are records for the same beneficiary. It validates the BIC and returns a base BIC under which to house the record in the National Claims History (NCH) databases. (All records for a beneficiary are stored under a single BIC.) For the ENCRYPTED Standard View, this field contains the Beneficiary Identification Code. (See Field #7 of the FI Outpatient Claim Fixed Group - Encrypted Standard View.)
19.	Claim MCO Paid Switch	CHAR	1	64	64	A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim. COBOL ALIAS: MCO_PD_IND DB2 ALIAS: CLM_MCO_PD_SW SAS ALIAS: MCOPDSW STANDARD ALIAS: CLM_MCO_PD_SW TITLE ALIAS: MCO_PAID_SW CODES: 1 = MCO has paid the provider for a claim Blank or 0 = MCO has not paid the provider for a claim

COMMENT:
Prior to Version H this field was named:
CLM_GHO_PD_SW.

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
20.	Claim Medicare Non Payment Reason Code	CHAR	1	65	65	The reason that no Medicare payment is made for services on an institutional claim. NOTE: Effective with Version I, this field was put on all institutional claim types. Prior to Version I, this field was present only on inpatient claims.

DB2 ALIAS: MDCR_NPMT_RSN_CD
SAS ALIAS: NOPAY_CD
STANDARD ALIAS: CLM_MDCR_NPMT_RSN_CD
SYSTEM ALIAS: LTNPMT
TITLE ALIAS: NON_PAYMENT_REASON

EDIT-RULES:
OPTIONAL

CODES:
REFER TO: CLM_MDCR_NPMT_RSN_TB
IN THE CODES APPENDIX

SOURCE:
CWF

21.	Claim Operating Physician UPIN Number	CHAR	6	66	71	On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgical procedure. This field is ENCRYPTED for the ENCRYPTED Standard View of the Outpatient files. DB2 ALIAS: OPRTG_UPIN SAS ALIAS: OP_UPIN STANDARD ALIAS: CLM_OPRTG_PHYSN_UPIN_NUM TITLE ALIAS: OPRTG_UPIN COMMENT: Prior to Version H this field was named: CLM_PRNCPAL_PRCDR_PHYSN_NUM and contained 10 positions (6-position UPIN and 4-position physician surname.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces. SOURCE: CWF
22. Claim Other Physician UPIN Number	CHAR	6	72	77	On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim. This field is ENCRYPTED for the ENCRYPTED Standard View of the Outpatient files. DB2 ALIAS: OTHR_UPIN SAS ALIAS: OT_UPIN STANDARD ALIAS: CLM_OTHR_PHYSN_UPIN_NUM TITLE ALIAS: OTH_PHYSN_UPIN COMMENT: Prior to Version H this field was named: CLM_OTHR_PHYSN_IDENT_NUM and contained 10 positions (6-position UPIN and 4-position other physician surname). NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces. SOURCE: CWF
23. Claim Outpatient Beneficiary Interim Deductible Amount	CHAR	13	78	90	Effective with version H, the amount paid by the beneficiary that is being applied to the deductible, as reported on the outpatient claim. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: INTRM_DDCTBL_AMT SAS ALIAS: INTRMDED STANDARD ALIAS: CLM_OP_BENE_INTRM_DDCTBL_AMT TITLE ALIAS: INTRM_DDCTBL

					EDIT-RULES: +9(9).99 SOURCE: CWF
24. Claim Outpatient Beneficiary Payment Amount	CHAR	13	91	103	Effective with Version H, the amount paid to the beneficiary for the services reported on the outpatient claim. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 9.2 DIGITS SIGNED

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					DB2 ALIAS: OP_BENE_PMT_AMT SAS ALIAS: BENEPMT STANDARD ALIAS: CLM_OP_BENE_PMT_AMT TITLE ALIAS: OP_BENE_PMT EDIT-RULES: +9(9).99 SOURCE: CWF
25. Claim Outpatient ESRD Method of Reimbursement Code	CHAR	1	104	104	Effective with Version H, the code denoting the method of reimbursement selected by the ESRD bene for home dialysis (i.e. whether home supplies are purchased through a facility or from a supplier.) NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: ESRD_REIMBRSMT_CD SAS ALIAS: ESRDMTHD STANDARD ALIAS: CLM_OP_ESRD_MTHD_REIMBRSMT_CD TITLE ALIAS: ESRD_REIMBRSMT_MTHD CODES: 0 = Not ESRD 1 = Method 1 - Home supplies purchased through a facility 2 = Method 2 - Home supplies purchased from a supplier. SOURCE:

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						CWF
26.	Claim Outpatient Provider Payment Amount	CHAR	13	105	117	Effective with Version H, the amount paid to the provider for the services reported on the outpatient claim. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeros in this field. 9.2 DIGITS SIGNED DB2 ALIAS: OP_PRVDR_PMT_AMT SAS ALIAS: PRVDRPMT STANDARD ALIAS: CLM_OP_PRVDR_PMT_AMT TITLE ALIAS: OP_PRVDR_PMT
						EDIT-RULES: +9(9).99 SOURCE: NCH
27.	Claim Outpatient Referral Code	CHAR	1	118	118	The code indicating the means by which the beneficiary was referred for outpatient services. DB2 ALIAS: CLM_OP_RFRL_CD SAS ALIAS: OP_RFRL STANDARD ALIAS: CLM_OP_RFRL_CD SYSTEM ALIAS: LTORFRL TITLE ALIAS: OP_REFERRAL_CODE CODES: REFER TO: CLM_OP_RFRL_TB IN THE CODES APPENDIX SOURCE: CWF
28.	Claim Outpatient Service Type Code	CHAR	1	119	119	Code indicating type and priority of outpatient services. DB2 ALIAS: OP_SRVC_TYPE_CD SAS ALIAS: OPSRVTYP STANDARD ALIAS: CLM_OP_SRVC_TYPE_CD TITLE ALIAS: OP_SERVICE_TYPE_CODE CODES: REFER TO: CLM_OP_SRVC_TYPE_TB IN THE CODES APPENDIX
29.	Claim Outpatient	CHAR	1	120	120	Effective with Version H, the code derived

Transaction Type Code

at CWF based on type of bill and provider number to identify the outpatient transaction type.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS: OP_TRANS_TYPE_CD
SAS ALIAS: TRANTYPE
STANDARD ALIAS: CLM_OP_TRANS_TYPE_CD
TITLE ALIAS: OP_TRANS_TYPE

CODES:
REFER TO: CLM_OP_TRANS_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
30.	Claim Payment Amount	CHAR	13	121	133	Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. **NOTE: In some situations, a negative claim payment amount may be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.) Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). It does NOT include the pass thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement. Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center

code '0022' to determine the total claim payment amount.

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total payment. The Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. NOTE: There is no CWF edit check to validate that the revenue center Medicare payment amount equals the claim level Medicare payment amount.

Under Home Health PPS, beneficiaries will be classified into an appropriate case mix category known as the Home Health Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment amount appropriate to the HIPPS code by computing 60% (for first episode) or 50% (for subsequent episodes) of the case mix episode payment. The payment is then wage index adjusted.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

For the final claim, PRICER calculates 100% of the amount due, because the final claim is processed as an adjustment to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider will actually receive the 40% or 50% payment.

Exceptions: For claims involving demos and BBA encounter data, the amount reported in this field may not just represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

For BBA encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan.

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT
DB2 ALIAS: CLM_PMT_AMT
SAS ALIAS: PMT_AMT
STANDARD ALIAS: CLM_PMT_AMT
TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was S9(7)V99. Also the noninstitutional claim records carried this field as a line item. Effective with Version H, this element is a claim level field across all claim types (and the line item has been renamed.)

SOURCE:
CWF

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					LIMITATIONS: Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM_DISP_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount.
31. Claim PPS Indicator Code	CHAR	1	134	134	Effective with Version H, the code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE). NOTE: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was pop-ulated with only the PPS indicator. Beginning with NCH weekly process date 6/5/98, this field was additionally populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces. COBOL ALIAS: PPS_IND DB2 ALIAS: CLM_PPS_IND_CD SAS ALIAS: PPS_IND STANDARD ALIAS: CLM_PPS_IND_CD TITLE ALIAS: PPS_IND

CODES:
REFER TO: CLM_PPS_IND_TB
IN THE CODES APPENDIX

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
32.	Claim Principal Diagnosis Code	CHAR	5	135	139	The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided. NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer. DB2 ALIAS: PRNCPAL_DGNS_CD SAS ALIAS: PDGNS_CD STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD TITLE ALIAS: PRINCIPAL_DIAGNOSIS EDIT-RULES: ICD-9-CM

SOURCE:
CWF

33.	Claim Query Code	CHAR	1	140	140	Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator). DB2 ALIAS: CLM_QUERY_CD SAS ALIAS: QUERY_CD STANDARD ALIAS: CLM_QUERY_CD TITLE ALIAS: QUERY_CD CODES: 0 = Credit adjustment 1 = Interim bill 2 = Home Health Agency (HHA) benefits exhausted (obsolete 7/98) 3 = Final bill 4 = Discharge notice (obsolete 7/98) 5 = Debit adjustment SOURCE: CWF
34.	Claim Service Classification Type Code	CHAR	1	141	141	The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification of

the type of service provided to the beneficiary.

COMMON ALIAS: TOB2
DB2 ALIAS: SRVC_CLSFCTN_CD
SAS ALIAS: TYPESRVC
STANDARD ALIAS: CLM_SRVC_CLSFCTN_TYPE_CD
TITLE ALIAS: TOB2

CODES:
REFER TO: CLM_SRVC_CLSFCTN_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
CWF

35. Claim Through Date	NUM	8	142	149	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date'). For the ENCRYPTED Standard View of the Outpatient files, the claim through date is coded as the quarter of the calendar year when the claim through date occurred.

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_THRU_DT
SAS ALIAS: THRU_DT
STANDARD ALIAS: CLM_THRU_DT
TITLE ALIAS: THRU_DATE

EDIT-RULES FOR ENCRYPTED DATA:
YYYYQ000 WHERE Q IS ONE OF THE
FOLLOWING VALUES.
1 = FIRST QUARTER OF THE CALENDAR YEAR
2 = SECOND QUARTER OF THE CALENDAR YEAR
3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:
CWF

36. Claim Total Charge Amount	CHAR	13	150	162	Effective with Version G, the total charges for all services included on the institutional claim. This field is redundant with revenue center code 0001/total charges.

9.2 DIGITS SIGNED

DB2 ALIAS: CLM_TOT_CHRG_AMT
SAS ALIAS: TOT_CHRG
STANDARD ALIAS: CLM_TOT_CHRG_AMT
TITLE ALIAS: CLAIM_TOTAL_CHARGES

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was
S9(7)V99.

SOURCE:
CWF

NAME	TYPE	LENGTH	BEG	END	CONTENTS
37. Claim Transaction Code	CHAR	1	163	163	The code derived by CWF to indicate the type of claim submitted by an institutional provider.

DB2 ALIAS: CLM_TRANS_CD
SAS ALIAS: TRANS_CD
STANDARD ALIAS: CLM_TRANS_CD
SYSTEM ALIAS: LTCLTRAN
TITLE ALIAS: TRANSACTION_CODE

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS

CODES:
REFER TO: CLM_TRANS_TB
IN THE CODES APPENDIX

SOURCE:
CWF

38. CWF Beneficiary Medicare Status Code	CHAR	2	164	165	The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT).

COBOL ALIAS: MSC
COMMON ALIAS: MSC
DB2 ALIAS: BENE_MDCR_STUS_CD
SAS ALIAS: MS_CD
STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD
SYSTEM ALIAS: LTMSC
TITLE ALIAS: MSC

DERIVATION:
CWF derives MSC from the following:
1. Date of Birth
2. Claim Through Date
3. Original/Current Reasons for entitlement
4. ESRD Indicator
5. Beneficiary Claim Number

Items 1,3,4,5 come from the CWF Beneficiary Master Record; item 2 comes from the FI/Carrier claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

CODES:
10 = Aged without ESRD
11 = Aged with ESRD
20 = Disabled without ESRD
21 = Disabled with ESRD
31 = ESRD only

COMMENT:
Prior to Version H this field was named: BENE_MDCR_STUS_CD. The name has been changed to distinguish this CWF-derived field from the EDB-derived MSC (BENE_MDCR_STUS_CD).

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
39.	FI Claim Action Code	CHAR	1	166	166	The type of action requested by the intermediary to be taken on an institutional claim. DB2 ALIAS: FI_CLM_ACTN_CD SAS ALIAS: ACTIONCD STANDARD ALIAS: FI_CLM_ACTN_CD TITLE ALIAS: ACTION_CD CODES: REFER TO: FI_CLM_ACTN_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: INTRMDRY_CLM_ACTN_CD. SOURCE: CWF
40.	FI Number	CHAR	5	167	171	The identification number assigned by HCFA to a fiscal intermediary authorized to process institutional claim records. DB2 ALIAS: FI_NUM

SAS ALIAS: FI_NUM
STANDARD ALIAS: FI_NUM
SYSTEM ALIAS: LTFI
TITLE ALIAS: INTERMEDIARY

CODES:
  REFER TO: FI_NUM_TB
            IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
FICARR_IDENT_NUM.

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
41.	FI Requested Claim Cancel Reason Code	CHAR	1	172	172	The reason that an intermediary requested cancelling a previously submitted institutional claim.

DB2 ALIAS: RQST_CNCL_RSN_CD
SAS ALIAS: CANCELCD
STANDARD ALIAS: FI_RQST_CLM_CNCL_RSN_CD
TITLE ALIAS: CANCEL_CD

CODES:
  REFER TO: FI_RQST_CLM_CNCL_RSN_TB
            IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
INTRMDRY_RQST_CLM_CNCL_RSN_CD.

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
42.	NCH Beneficiary Blood Deductible Liability Amount	CHAR	13	173	185	The amount of money for which the intermediary determined the beneficiary is liable for the blood deductible.

9.2 DIGITS SIGNED

DB2 ALIAS: BLOOD_DDCTBL_AMT
SAS ALIAS: BLDDEDAM
STANDARD ALIAS: NCH_BENE_BLOOD_DDCTBL_AMT
TITLE ALIAS: BLOOD_DEDUCTIBLE

EDIT-RULES:
+9(9).99

DERIVATION:
DERIVED FROM:
  CLM_VAL_CD

CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to '06' move the corresponding value amount to NCH_BENE_BLOOD_DDCTBL_AMT.

COMMENT:
Prior to Version H, this field was named: BENE_BLOOD_DDCTBL_LBLTY_AMT and the field size was S9(5)V99. Also, for OP claims, this field was stored in a blood trailer. Version H eliminated the OP blood trailer.

SOURCE:
NCH QA PROCESS

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
43.	NCH Beneficiary Part B Coinsurance Amount	CHAR	13	186	198	The amount of money for which the intermediary has determined that the beneficiary is liable for Part B coinsurance on the institutional claim. 9.2 DIGITS SIGNED DB2 ALIAS: PTB_COINSRNC_AMT SAS ALIAS: PTB_COIN STANDARD ALIAS: NCH_BENE_PTB_COINSRNC_AMT TITLE ALIAS: BENE_PTB_COINSURANCE_AMT

EDIT-RULES:
+9(9).99

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES (Effective 10/93):
Based on the presence of value codes A2, B2 or C2 move the related value amount to the NCH_BENE_PTB_COINSRNC_AMT. *NOTE: Prior to 10/93, this field was present on the claim transmitted by CWF.

COMMENT:
Prior to Version H this field was named: BENE_PTB_COINSRNC_LBLTY_AMT and the field size was s9(5)V99.

SOURCE:
NCH QA PROCESS

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
44.	NCH Beneficiary Part B Deductible Amount	CHAR	13	199	211	The amount of money for which the intermediary or carrier has determined that the beneficiary is liable for the Part B cash deductible on the claim. 9.2 DIGITS SIGNED DB2 ALIAS: NCH_PTB_DDCTBL_AMT SAS ALIAS: PTB_DED STANDARD ALIAS: NCH_BENE_PTB_DDCTBL_AMT TITLE ALIAS: PTB_DDCTBL EDIT RULES: +9(9).99 DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT DERIVATION RULES (Effective 10/93): Based on the presence of value codes A1, B1, or C1 move the related value amount to the NCH_BENE_PTB_DDCTBL_LBLTY_AMT and field size was s9(5)V99. SOURCE: NCH QA PROCESS

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
45.	NCH Blood Deductible Pints Quantity	CHAR	4	212	215	The quantity of blood pints applied (blood deductible). 3 DIGITS SIGNED DB2 ALIAS: BLOOD_DDCTBL_QTY SAS ALIAS: BLDDEDPT STANDARD ALIAS: NCH_BLOOD_DDCTBL_PT_QTY TITLE ALIAS: BLOOD_PINTS_DEDUCTIBLE EDIT-RULES: +999 DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT DERIVATION RULES: Based on the presence of value code equal to 38 move the related value amount to the NCH_BLOOD_DDCTBL_PT_QTY.

					COMMENT: Prior to Version H this field was named: CLM_BLOOD_DDCTBL_PT_QTY. Also for outpatient claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer. SOURCE: NCH QA Process
46.	NCH Blood Pints Furnished Quantity	CHAR	4	216 219	Number of whole pints of blood furnished to the beneficiary. 3 DIGITS SIGNED DB2 ALIAS: NCH_BLOOD_PT_FRNSH SAS ALIAS: BLDFRNSH STANDARD ALIAS: NCH_BLOOD_PT_FRNSH_QTY TITLE ALIAS: BLOOD_PINTS_FURNISHED EDIT-RULES: +999 DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						DERIVATION RULES: Based on the presence of value code equal to 37 move the related value amount to the NCH_BLOOD_PT_FRNSH_QTY. COMMENT: Prior to Version H this field was named: CLM_BLOOD_PT_FRNSH_QTY. Also for outpatient claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer. SOURCE: NCH QA Process
47.	NCH Blood Pints Not Replaced Quantity	CHAR	4	220	223	Number of whole pints of blood not replaced. 3 DIGITS SIGNED DB2 ALIAS: BLOOD_PT_NRPLC_QTY SAS ALIAS: BLDNRPLC STANDARD ALIAS: NCH_BLOOD_PT_NRPLC_QTY TITLE ALIAS: BLOOD_PINTS_NOT_REPLACED

EDIT-RULES:
+999

DERIVATION:
DERIVED FROM:
  CLM_VAL_CD
  CLM_VAL_AMT

DERIVATION RULES:
Subtract value code 39 amount from value code
37 amount and move the result to
NCH_BLOOD_PT_NRPLC_QTY.

COMMENT:
Prior to Version H this field was named:
CLM_BLOOD_PT_NRPLC_QTY. Also for outpatient
claims this field was stored in a blood
trailer. Version H eliminated the outpatient
blood trailer.

SOURCE:
NCH QA Process

			POSITIONS		
NAME	TYPE	LENGTH	BEG	END	CONTENTS
48. NCH Blood Pints Replaced Quantity	CHAR	4	224	227	Number of whole pints of blood replaced. 3 DIGITS SIGNED

DB2 ALIAS: BLOOD_PT_RPLC_QTY
SAS ALIAS: BLD_RPLC
STANDARD ALIAS: NCH_BLOOD_PT_RPLC_QTY
TITLE ALIAS: BLOOD_PINTS_REPLACED

EDIT-RULES:
+999

DERIVATION:
DERIVED FROM:
  CLM_VAL_CD
  CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to
39 move the related value amount to the
NCH_BLOOD_PT_RPLC_QTY.

COMMENT:
Prior to Version H this field was named:
CLM_BLOOD_PT_RPLC_QTY. Also for outpatient
claims this field was stored in a blood
trailer. Version H eliminated the outpatient
blood trailer.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					SOURCE: NCH QA Process
49. NCH Near Line Record Identification Code	CHAR	1	228	228	A code defining the type of claim record being processed. COMMON ALIAS: RIC DB2 ALIAS: NEAR_LINE_RIC_CD SAS ALIAS: RIC_CD STANDARD ALIAS: NCH_NEAR_LINE_RIC_CD TITLE ALIAS: RIC CODES: REFER TO: NCH_NEAR_LINE_RIC_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: RIC_CD. SOURCE: NCH
50. NCH Near-Line Record Version Code	CHAR	1	229	229	The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored:

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					DB2 ALIAS: NCH_REC_VRSN_CD SAS ALIAS: REC_LVL STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD TITLE ALIAS: NCH_VERSION CODES: A = Record format as of January 1991 B = Record format as of April 1991 C = Record format as of May 1991 D = Record format as of January 1992 E = Record format as of March 1992 F = Record format as of May 1992 G = Record format as of October 1993 H = Record format as of September 1998 I = Record format as of July 2000 COMMENT: Prior to Version H this field was anmed: CLM_NEAR_LINE_REC_VRSN_CD. SOURCE: NCH
51. NCH Payment and Edit Record Identification Code	CHAR	1	230	230	The code used for payment and editing purposes that indicates the type of institutional claim record.

					DB2 ALIAS: PMT_EDIT_RIC_CD SAS ALIAS: PE_RIC STANDARD ALIAS: NCH_PMT_EDIT_RIC_CD TITLE ALIAS: NCH_PAYMENT_EDIT_RIC CODES: C = Inpatient hospital, SNF D = Outpatient E = Religious Nonmedical Health Care Institutions (eff. 8/00 Christian Science, prior to 7/00 F = Home Health Agency (HHA) G = Discharge notice (obsoleted 7/98) I = Hospice COMMENT: Prior to Version H this field was named: PMT_EDIT_RIC_CD. SOURCE: NCH QA Process
52. NCH Primary Payer Claim Paid Amount	CHAR	13	231	243	The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on an institutional, carrier, or DMERC claim.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					9.2 DIGITS SIGNED DB2 ALIAS: PRMRY_PYR_PD_AMT SAS ALIAS: PRPAYAMT STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT TITLE ALIAS: PRIMARY_PAYER_AMOUNT EDIT-RULES: +9(9).99 COMMENT: Prior to Version H this field was named: BENE_PRMRY_PYR_CLM_PMT_AMT and the field size was S9(7)V99. SOURCE: NCH
53. NCH Primary Payer Code	CHAR	1	244	244	The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's health insurance bills. DB2 ALIAS: NCH_PRMRY_PYR_CD

SAS ALIAS: PRPAY_CD
STANDARD ALIAS: NCH_PRMRY_PYR_CD
TITLE ALIAS: PRIMARY_PAYER_CD

DERIVATION:
DERIVED FROM:
   CLM_VAL_CD
   CLM_VAL_AMT

DERIVATION RULES

  SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE
  CLM_VAL_CD = '12'

  SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE
  CLM_VAL_CD = '13'

  SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE
  CLM_VAL_CD = '16' and CLM_VAL_AMT is zeroes

  SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE
  CLM_VAL_CD = '14'

  SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE
  CLM_VAL_CD = '15'

  SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE
  CLM_VAL_CD = '16' (CLM_VAL_AMT not
  equal to zeroes)

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

  SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE
  CLM_VAL_CD = '43'

  SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE
  CLM_VAL_CD = '41'

  SET NCH_PRMRY_PYR_CD TO 'I' WHERE THE
  CLM_VAL_CD = '42'

  SET NCH_PRMRY_PYR_CD TO 'L' (or prior to 4/97
  set code to 'J') WHERE THE CLM_VAL_CD = '47'

CODES:
  REFER TO: BENE_PRMRY_PYR_TB
            IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
BENE_PRMRY_PYR_CD.

SOURCE:
NCH

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
54. NCH Professional Component Charge Amount	CHAR	13	245	257	Effective with Version H, for inpatient and out-patient claims, the amount of physician and other professional charges covered under Medicare Part B (used for internal CWFMQA editing purposes and other internal processes (e.g. if computing interim payment these charges are deducted)). NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). 9.2 DIGITS SIGNED DB2 ALIAS: PROFNL_CMPNT_AMT SAS ALIAS: PCCHGAMT STANDARD ALIAS: NCH_PROFNL_CMPNT_CHRG_AMT TITLE ALIAS: PROFNL_CMPNT_CHARGES EDIT-RULES: +9(9).99 DERIVATION: 1. IF INPATIENT - DERIVED FROM: CLM_VAL_CD Clm_VAL_AMT DERIVATION RULES: Based on the presence of value code 04 or 05 move the related value amount to the NCH_PROFNL_CMPNT_CHRG_AMT.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					2. IF OUTPATIENT - DERIVED FROM: REV_CNTR_CD REV_CNTR_TOT_CHRG_AMT DERIVATION RULES (Effective 10/98): Based on the presence of revenue center codes 096X, 097X & 098X move the related total charge amount to NCH_PROFNL_CMPNT_CHRG_AMT. NOTE1: During the Version H conversion, this field was populated with data throughout history BUT the derivation rule applied to the outpatient claim was incomplete (i.e., revenue codes 0972, 0973, 0974 and 0979 were omitted from the calcu-lation). SOURCE: NCH QA Process

55. NCH Provider State Code	CHAR	2	258	259	Effective with Version H, the two position SSA state code where provider facility is located. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). DB2 ALIAS: NCH_PRVDR_STATE_CD SAS ALIAS: PRSTATE STANDARD ALIAS: NCH_PRVDR_STATE_CD TITLE ALIAS: PROVIDER_STATE_CD DERIVATION: DERIVED FROM: NCH PRVDR_NUM DERIVATION RULES: SET NCH_PRVDR_STATE_CD TO PRVDR_NUM POS1-2. FOR PRVDR_NUM POS1-2 EQUAL '55 SET NCH_PRVDR_STATE_CD TO '05'. FOR PRVDR_NUM POS1-2 EQUAL '67 SET NCH_PRVDR_STATE_CD TO '45'. FOR PRVDR_NUM POS1-2 EQUAL '68 SET NCH_PRVDR_STATE_CD TO '10'. CODES: REFER TO: GEO_SSA_STATE_TB IN THE CODES APPENDIX SOURCE: NCH

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
56. Outpatient Claim Diagnosis Code Count	NUM	2	260	261	The count of the number of diagnosis codes (both principal and other) reported on an outpatient claim. The purpose of this count is to indicate how many claim diagnosis trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: OP_CLM_DGNS_CD_CNT SAS ALIAS: OPDGNCNT STANDARD ALIAS: OP_CLM_DGNS_CD_CNT EDIT-RULES: RANGE: 0 TO 10 COMMENT: Prior to Version H this field was named: CLM_OTHR_DGNS_CD_CNT and the principal was not included in the count.

SOURCE:
NCH

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
57.	Outpatient Claim Procedure Code Count	NUM	2	262	263	The count of the number of procedure codes (both principal and other) reported on an outpatient claim. The purpose of this count is to indicate how many claim procedure trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: OP_PRCDR_CD_CNT SAS ALIAS: OPPRCNT STANDARD ALIAS: OP_CLM_PRCDR_CD_CNT EDIT-RULES: RANGE: 0 TO 6 COMMENT: Prior to Version H this field was named: CLM_PRCDR_CD_CNT. SOURCE: CWF
58.	Outpatient Claim Related Condition Code Count	NUM	2	264	265	The count of the number of condition codes reported on an outpatient claim. The purpose of this count is to indicate how many condition code trailer are present. 2 DIGITS UNSIGNED DB2 ALIAS: OP_RLT_COND_CD_CNT SAS ALIAS: OPCONCNT STANDARD ALIAS: OP_CLM_RLT_COND_CD_CNT

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						EDIT-RULES: RANGE: 0 TO 30 COMMENT: Prior to Version H this field was named: CLM_RLT_COND_CD_CNT. SOURCE: NCH
59.	Outpatient Claim Related Occurrence Code Count	NUM	2	266	267	The count of the number of occurrence codes reported on reported on an outpatient claim. The purpose of this count is to include how many occurrence code trailers are present. 2 DIGITS UNSIGNED

DB2 ALIAS: OP_OCRNC_CD_CNT
SAS ALIAS: OPOCRCNT
STANDARD ALIAS: OP_CLM_RLT_OCRNC_CD_CNT

EDIT-RULES:
RANGE: 0 TO 30

COMMENT:
Prior to Version H this field was named:
CLM_RLT_OCRNC_CD_CNT.

SOURCE:
NCH

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
60.	Outpatient Claim Value Code Count	NUM	2	268	269	The count of the number of value codes reported on an outpatient claim. The purpose of the count is to indicate how many value code trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: OP_CLM_VAL_CD_CNT SAS ALIAS: OPVALCNT STANDARD ALIAS: OP_CLM_VAL_CD_CNT EDIT-RULES: RANGE: 0 TO 36 COMMENT: Prior to Version H this field was named: CLM_VAL_CD_CNT. SOURCE: NCH

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
61.	Outpatient Revenue Center Code Count	NUM	2	270	271	The count of the number of revenue codes reported on an outpatient claim. The purpose of the count is to indicate how many revenue center trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: OP_REV_CNTR_CD_CNT SAS ALIAS: OPREVCNT STANDARD ALIAS: OP_REV_CNTR_CD_I_CNT EDIT-RULES: RANGE: 0 TO 45 COMMENT: Prior to Version H this field was named:

CLM_REV_CNTR_CD_CNT.

NOTE: During the Version 'I' conversion the number of occurrences changed to 45 (per segment - 450 total for claim). For claims prior to Version 'I' the number of occurrences was 58, but in the conversion we made all claims back to service year 1991 contain only 45 revenue center lines. It is possible that claims prior to 1991 will have 2 segments if they contained more than 45 revenue lines.

SOURCE:
NCH

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
62.	Patient Discharge Status Code	CHAR	2	272	273	The code used to identify the status of the patient as of the CLM_THRU_DT.

COMMON ALIAS: DISCHARGE_DESTINATION/PATIENT_STATUS
DB2 ALIAS: PTNT_DSCHRG_STUS
SAS ALIAS: STUS_CD
STANDARD ALIAS: PTNT_DSCHRG_STUS_CD
SYSTEM ALIAS: LTCLMST
TITLE ALIAS: PTNT_DSCHRG_STUS_CD

CODES:
REFER TO: PTNT_DSCHRG_STUS_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CLM_STUS_CD.

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
63.	Provider Number	CHAR	6	274	279	The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.

DB2 ALIAS: PRVDR_NUM
SAS ALIAS: PROVIDER
STANDARD ALIAS: PRVDR_NUM
TITLE ALIAS: PROVIDER_NUMBER

CODES:
REFER TO: PRVDR_NUM_TB
IN THE CODES APPENDIX

SOURCE:
OSCAR

FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

****

C L A I M D I A G N O S I S G R O U P R E C O R D

****

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	FI Outpatient Claim Diagnosis Group Record - Encrypted Standard View	GROUP	26			Claim Diagnosis Group Record for the Encrypted Standard View of the Outpatient Version I NCH Nearline File. The number of claim diagnosis trailers is determined by the claim diagnosis code count. The principal diagnosis is the first occurrence. The 'E' code (ICD-9-CM code for the external cause of an injury, poisoning, or adverse affect) is stored as the last occurrence. The principal diagnosis and the 'E' code are also stored (redundantly) in the fixed record. NOTE: Prior to Version H this group was named: CLM_OTHR_DGNS_GRP and did not contain the CLM_PRNCPAL_DGNS_CD. OCCURS: UP TO 10 TIMES DEPENDING ON OP_CLM_DGNS_CD_CNT STANDARD ALIAS: UTLOUTPI_CLM_DGNS_GRP
1.	Record Length Count	NUM	5	1	5	The length of the Claim Diagnosis Group Record. 5 DIGITS UNSIGNED STANDARD ALIAS: TRAIL_BYTE_COUNT
2.	Record Number	NUM	9	6	14	A sequentially assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim. STANDARD ALIAS: TRAIL_CLAIM_NO
3.	Record Type	NUM	2	15	16	Type of Record. STANDARD ALIAS: TRAIL_REC_TYPE CODES: 00 = Fixed/Main Group 01 = Carrier Line Group

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					02 = Claim Demonstration ID Group 03 = Claim Diagnosis Group 04 = Claim Health PlanID Group
					05 = Claim Occurrence Span Group 06 = Claim Procedure Group 07 = Claim Related Condition Group 08 = Claim Related Occurrence Group 09 = Claim Value Group 10 = MCO Period Group 11 = NCH Edit Group 12 = NCH Patch Group 13 = DMERC Line Group 14 = Revenue Center Group
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim. STANDARD ALIAS: TRAIL_CLAIM_SEQ
5. NCH Claim Type Code	NUM	2	20	21	The code used to identify the type of claim record being processed in NCH. NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991). NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added. STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD DERIVATION: FFS CLAIM TYPE CODES DERIVED FROM: NCH CLM_NEAR_LINE_RIC_CD NCH PMT_EDIT_RIC_CD NCH CLM_TRANS_CD NCH PRVDR_NUM INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (Pre-HDC processing -- AVAILABLE IN NCH) CLM_MCO_PD_SW CLM_RLT_COND_CD MCO_CNTRCT_NUM MCO_OPTN_CD MCO_PRD_EFCTV_DT MCO_PRD_TRMNTN_DT

FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM
					INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.
					PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) CARR_NUM CLM_DEMO_ID_NUM
					OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM
					OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD
					DERIVATION RULES: SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U' 2. PMT_EDIT_RIC_CD EQUAL 'F' 3. CLM_TRANS_CD EQUAL '5' SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E' 3. CLM_TRANS_CD EQUAL '0' OR '4' 4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y' OR 'Z' SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'

3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
OR 'Z'

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
CLSFCTN_TYPE_CD = '2', '3' OR '4' &
CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E' 3. CLM_TRANS_CD EQUAL '1' '2' OR '3' 4. FI_NUM = 80881
					SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. FI_NUM = 80881 AND 2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_ TYPE_CD = '1'; CLM_FREQ_CD = 'Z'
					SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'O' 2. HCPCS_CD not on DMEPOS table
					SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'O' 2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).
					SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM-- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CARR_NUM = 80882 AND 2. CLM_DEMO_ID_NUM = 38
					SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD not on DMEPOS table
					SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).
					CODES: REFER TO: NCH_CLM_TYPE_TB IN THE CODES APPENDIX
					SOURCE: NCH
6. Claim Diagnosis Code	CHAR	5	22	26	The ICD-9-CM based code identifying the beneficiary's principal or other diagnosis (including E code).

NOTE:
Prior to Version H, the principal diagnosis
code was not stored with the 'OTHER' diagnosis
codes. During the Version H conversion the
CLM_PRNCPAL_DGNS_CD was added as the first
occurrence.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					DB2 ALIAS: CLM_DGNS_CD SAS ALIAS: DGNS_CD STANDARD ALIAS: CLM_DGNS_CD TITLE ALIAS: DIAGNOSIS EDIT-RULES: ICD-9-CM COMMENT: Prior to Version H this field was named: CLM_OTHR_DGNS_CD.

1 FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

****

C L A I M P R O C E D U R E G R O U P R E C O R D

****

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	FI Outpatient Claim Procedure Group Record - Encrypted Standard View	GROUP	33			Claim Procedure Group Record for the Encrypted Standard View of the Outpatient Version I Nearline File. The number of claim procedure trailers is determined by the claim procedure code count. Prior to 10/93 up to 10 occurrences could be reported on an institutional claim. Beginning 10/93, up to six occurrences (one principal; five others) may be reported. OCCURS: UP TO 6 TIMES DEPENDING ON OP_CLM_PRCDR_CD_CNT STANDARD ALIAS: UTLOUTPI_CLM_PRCDR_GRP
1.	Record Length Count	NUM	5	1	5	The length of the Claim Procedure Group Record.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					5 DIGITS UNSIGNED STANDARD ALIAS: TRAIL_BYTE_COUNT
2. Record Number	NUM	9	6	14	A sequentially assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim. STANDARD ALIAS: TRAIL_CLAIM_NO
3. Record Type	NUM	2	15	16	Type of Record. STANDARD ALIAS: TRAIL_REC_TYPE CODES: 00 = Fixed/Main Group 01 = Carrier Line Group 02 = Claim Demonstration ID Group 03 = Claim Diagnosis Group 04 = Claim Health PlanID Group 05 = Claim Occurrence Span Group 06 = Claim Procedure Group 07 = Claim Related Condition Group 08 = Claim Related Occurrence Group 09 = Claim Value Group 10 = MCO Period Group 11 = NCH Edit Group 12 = NCH Patch Group 13 = DMERC Line Group 14 = Revenue Center Group
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim. STANDARD ALIAS: TRAIL_CLAIM_SEQ
5. NCH Claim Type Code	CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH. NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991). NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added. STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					DERIVATION: FFS CLAIM TYPE CODES DERIVED FROM: NCH CLM_NEAR_LINE_RIC_CD NCH PMT_EDIT_RIC_CD NCH CLM_TRANS_CD NCH PRVDR_NUM INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (Pre-HDC processing -- AVAILABLE IN NCH) CLM_MCO_PD_SW CLM_RLT_COND_CD MCO_CNTRCT_NUM MCO_OPTN_CD MCO_PRD_EFCTV_DT MCO_PRD_TRMNTN_DT INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD. PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) CARR_NUM CLM_DEMO_ID_NUM OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD DERIVATION RULES: SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'

2. PMT_EDIT_RIC_CD EQUAL 'F'
3. CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
    OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
    OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
    CLSFCTN_TYPE_CD = '2', '3' OR '4' &
    CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 - 12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
   MCO_OPTN_CD = 'C'
   CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
   MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
   ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
   TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM-- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

COMMENT:
Prior to Version H this field was named:
CLM_OTHR_DGNS_CD.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
6. Claim Procedure Code	CHAR	4	22	25	The ICD-9-CM code that indicates the principal or other procedure performed during the period covered by the institutional claim. DB2 ALIAS: CLM_PRCDR_CD SAS ALIAS: PRCDR_CD STANDARD ALIAS: CLM_PRCDR_CD TITLE ALIAS: PROCEDURE_CODE EDIT-RULES: ICD-9-CM SOURCE: CWF

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
7. Claim Procedure Performed Date	NUM	8	26	33	On an institutional claim, the date on which the principal or other procedure was performed. For the ENCRYPTED Standard View of the Outpatient files, the claim procedure performed date is coded as the quarter of the calendar year when the procedure was performed. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_PRCDR_PRFRM_DT SAS ALIAS: PRCDR_DT STANDARD ALIAS: CLM_PRCDR_PRFRM_DT TITLE ALIAS: PROCEDURE_DATE EDIT-RULES FOR ENCRYPTED DATA: YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES. 1 = FIRST QUARTER OF THE CALENDAR YEAR

2 = SECOND QUARTER OF THE CALENDAR YEAR
3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:
CWF

****

C L A I M R E L A T E D C O N D I T I O N G R O U P R E C O R D

****

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	FI Outpatient Claim Related Condition Group Record - Encrypted Standard View	GROUP	23			Claim Related Condition Group Record for the Encrypted Standard View of the Outpatient version I NCH Nearline File. The number of claim related condition trailers is determined by the claim related condition code count. Effective 10/93, up to 30 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported. OCCURS: UP TO 30 TIMES DEPENDING ON OP_CLM_RLT_COND_CD_CNT STANDARD ALIAS: UTLOUTPI_CLM_RLT_COND_GRP
1.	Record Length Count	NUM	5	1	5	The length of the Claim Related Condition Group Record. 5 DIGITS UNSIGNED STANDARD ALIAS: TRAIL_BYTE_COUNT
2.	Record Number	NUM	9	6	14	A sequentially assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim. STANDARD ALIAS: TRAIL_CLAIM_NO
3.	Record Type	NUM	2	15	16	Type of Record. STANDARD ALIAS: TRAIL_REC_TYPE CODES: 00 = Fixed/Main Group

FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					01 = Carrier Line Group 02 = Claim Demonstration ID Group 03 = Claim Diagnosis Group 04 = Claim Health PlanID Group 05 = Claim Occurrence Span Group 06 = Claim Procedure Group 07 = Claim Related Condition Group 08 = Claim Related Occurrence Group
					09 = Claim Value Group 10 = MCO Period Group 11 = NCH Edit Group 12 = NCH Patch Group 13 = DMERC Line Group 14 = Revenue Center Group
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim. STANDARD ALIAS: TRAIL_CLAIM_SEQ
5. NCH Claim Type Code	CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH. NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991). NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added. STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD DERIVATION: FFS CLAIM TYPE CODES DERIVED FROM: NCH CLM_NEAR_LINE_RIC_CD NCH PMT_EDIT_RIC_CD NCH CLM_TRANS_CD NCH PRVDR_NUM INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (Pre-HDC processing -- AVAILABLE IN NCH) CLM_MCO_PD_SW CLM_RLT_COND_CD MCO_CNTRCT_NUM MCO_OPTN_CD MCO_PRD_EFCTV_DT MCO_PRD_TRMNTN_DT

FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD
					NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD. PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) CARR_NUM CLM_DEMO_ID_NUM OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD DERIVATION RULES: SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U' 2. PMT_EDIT_RIC_CD EQUAL 'F' 3. CLM_TRANS_CD EQUAL '5' SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E' 3. CLM_TRANS_CD EQUAL '0' OR '4' 4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y' OR 'Z' SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'

3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
CLSFCTN_TYPE_CD = '2', '3' OR '4' &
CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_ TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM-- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

COMMENT:

						Prior to Version H this field was named: CLM_OTHR_DGNS_CD.
	6. Claim Related Condition Code	CHAR	2	22	23	The code that indicates a condition relating to an institutional claim that may affect payer processing. DB2 ALIAS: CLM_RLT_COND_CD SAS ALIAS: RLT_COND STANDARD ALIAS: CLM_RLT_COND_CD SYSTEM ALIAS: LTCOND TITLE ALIAS: RELATED_CONDITION_CD CODES: 01 THRU 16 = Insurance related 17 THRU 30 = Special condition 31 THRU 35 = Student status codes which are required when a patient is a dependent child over 18 years old

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						36 THRU 45 = Accommodation 46 THRU 54 = CHAMPUS information 55 THRU 59 = Skilled nursing facility 60 THRU 70 = Prospective payment 71 THRU 99 = Renal dialysis setting A0 THRU B9 = Special program codes C0 THRU C9 = PRO approval services D0 THRU W0 = Change conditions CODES: REFER TO: CLM_RLT_COND_TB IN THE CODES APPENDIX SOURCE: CWF

1 FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

****

C L A I M R E L A T E D O C C U R R E N C E G R O U P R E C O R D

****

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	FI Outpatient Claim Related Occurrence Group Record - Encrypted Standard	GROUP	31			Claim Related Occurrence Group Record for the Encrypted Standard View of the Outpatient files version I NCH Nearline File.

The number of claim related occurrence trailers is determined by the claim related occurrence code count. Effective 10/93, up to 30 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

OCCURS: UP TO 30 TIMES
DEPENDING ON OP_CLM_RLT_OCRNC_CD_CNT

STANDARD ALIAS: UTLOUTPI_CLM_RLT_OCRNC_GRP

1. Record Length Count	NUM	5	1	5	The length of the Claim Related Occurrence Group Record. 5 DIGITS UNSIGNED STANDARD ALIAS: TRAIL_BYTE_COUNT
2. Record Number	NUM	9	6	14	A sequentially assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim. STANDARD ALIAS: TRAIL_CLAIM_NO
3. Record Type	NUM	2	15	16	Type of Record. STANDARD ALIAS: TRAIL_REC_TYPE CODES: 00 = Fixed/Main Group 01 = Carrier Line Group 02 = Claim Demonstration ID Group 03 = Claim Diagnosis Group 04 = Claim Health PlanID Group 05 = Claim Occurrence Span Group 06 = Claim Procedure Group 07 = Claim Related Condition Group 08 = Claim Related Occurrence Group 09 = Claim Value Group

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					10 = MCO Period Group 11 = NCH Edit Group 12 = NCH Patch Group 13 = DMERC Line Group 14 = Revenue Center Group
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center

data, which can occur multiple times for one claim.

STANDARD ALIAS: TRAIL_CLAIM_SEQ

5. NCH Claim Type Code	CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.

STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD

DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
- NCH CLM_NEAR_LINE_RIC_CD
- NCH PMT_EDIT_RIC_CD
- NCH CLM_TRANS_CD
- NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(Pre-HDC processing -- AVAILABLE IN NCH)
- CLM_MCO_PD_SW
- CLM_RLT_COND_CD
- MCO_CNTRCT_NUM
- MCO_OPTN_CD
- MCO_PRD_EFCTV_DT
- MCO_PRD_TRMNTN_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(HDC processing -- AVAILABLE IN NMUD)
- FI_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD)
- FI_NUM
- CLM_FAC_TYPE_CD
- CLM_SRVC_CLSFCTN_TYPE_CD
- CLM_FREQ_CD

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(AVAILABLE IN NMUD)

CARR_NUM
CLM_DEMO_ID_NUM

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(AVAILABLE IN NMUD)
FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
DERIVED FROM: (AVAILABLE IN NMUD)
FI_NUM
CLM_FAC_TYPE_CD
CLM_SRVC_CLSFCTN_TYPE_CD
CLM_FREQ_CD

DERIVATION RULES:

SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
2. PMT_EDIT_RIC_CD EQUAL 'F'
3. CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
CLSFCTN_TYPE_CD = '2', '3' OR '4' &
CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

COMMENT:
Prior to Version H this field was named: CLM_OTHR_DGNS_CD.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
6.	Claim Related Occurrence Code	CHAR	2	22	23	The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date. DB2 ALIAS: CLM_RLT_OCRNC_CD SAS ALIAS: OCRNC_CD STANDARD ALIAS: CLM_RLT_OCRNC_CD SYSTEM ALIAS: LTOCRNC TITLE ALIAS: OCCURRENCE_CD CODES: 01 THRU 09 = Accident 10 THRU 19 = Medical condition 20 THRU 39 = Insurance related

40 THRU 69 = Service related
A1-A3 = Miscellaneous

CODES:
REFER TO: CLM_RLT_OCRNC_TB
IN THE CODES APPENDIX

SOURCE:
CWF

7.	Claim Related Occurrence Date	NUM	8	24	31	The date associated with a significant event related to an institutional claim that may affect payer processing. For the ENCRYPTED Standard View of the Outpatient files, the claim procedure performed date is coded as the quarter of the calendar year when the procedure was performed. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_RLT_OCRNC_DT SAS ALIAS: OCRNCDT STANDARD ALIAS: CLM_RLT_OCRNC_DT TITLE ALIAS: RLT_OCRNC_DT EDIT-RULES FOR ENCRYPTED DATA: YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES. 1 = FIRST QUARTER OF THE CALENDAR YEAR 2 = SECOND QUARTER OF THE CALENDAR YEAR 3 = THIRD QUARTER OF THE CALENDAR YEAR 4 = FOURTH QUARTER OF THE CALENDAR YEAR SOURCE: CWF

****

C L A I M V A L U E G R O U P R E C O R D

****

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	FI Outpatient Claim Value Group Record - Encrypted Standard View	GROUP	36			Claim Value Code Group Record for the Encrypted Standard View of the Outpatient version I NCH Nearline File. The number of claim value data trailers present is determined by the claim

value code count. Effective 10/93,
up to 36 occurrences can be reported on an
institutional claim. Prior to 10/93, up
to 10 occurrences could be reported.

OCCURS: UP TO 36 TIMES
DEPENDING ON OP_CLM_VAL_CD_CNT

STANDARD ALIAS: UTLOUTPI_CLM_VAL_GRP

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
1. Record Length Count	NUM	5	1	5	The length of the Claim Value Code Group Record. 5 DIGITS UNSIGNED STANDARD ALIAS: TRAIL_BYTE_COUNT
2. Record Number	NUM	9	6	14	A sequentially assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim. STANDARD ALIAS: TRAIL_CLAIM_NO
3. Record Type	NUM	2	15	16	Type of Record. STANDARD ALIAS: TRAIL_REC_TYPE CODES: 00 = Fixed/Main Group 01 = Carrier Line Group 02 = Claim Demonstration ID Group 03 = Claim Diagnosis Group 04 = Claim Health PlanID Group 05 = Claim Occurrence Span Group 06 = Claim Procedure Group 07 = Claim Related Condition Group 08 = Claim Related Occurrence Group 09 = Claim Value Group

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					10 = MCO Period Group 11 = NCH Edit Group 12 = NCH Patch Group 13 = DMERC Line Group 14 = Revenue Center Group
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim. STANDARD ALIAS: TRAIL_CLAIM_SEQ

5. NCH Claim Type Code	CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH. NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991). NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added. SYSTEM ALIAS: TRAIL_NCH_CLM_TYPE_CD DERIVATION: FFS CLAIM TYPE CODES DERIVED FROM: NCH CLM_NEAR_LINE_RIC_CD NCH PMT_EDIT_RIC_CD NCH CLM_TRANS_CD NCH PRVDR_NUM INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (Pre-HDC processing -- AVAILABLE IN NCH) CLM_MCO_PD_SW CLM_RLT_COND_CD MCO_CNTRCT_NUM MCO_OPTN_CD MCO_PRD_EFCTV_DT MCO_PRD_TRMNTN_DT INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD. PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) CARR_NUM CLM_DEMO_ID_NUM OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(AVAILABLE IN NMUD)
FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
DERIVED FROM: (AVAILABLE IN NMUD)
FI_NUM
CLM_FAC_TYPE_CD
CLM_SRVC_CLSFCTN_TYPE_CD
CLM_FREQ_CD

DERIVATION RULES:

SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
2. PMT_EDIT_RIC_CD EQUAL 'F'
3. CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1. FI_NUM = 80881

2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
CLSFCTN_TYPE_CD = '2', '3' OR '4' &
CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one or
more line item(s) match the HCPCS on the

DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
CONDITIONS ARE MET:
1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD on DMEPOS table (NOTE: if one or
more line item(s) match the HCPCS on the
DMEPOS table).

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

COMMENT:
Prior to Version H this field was named:
CLM_OTHR_DGNS_CD.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
6. Claim Value Code	CHAR	2	22	23	The code indicating the value of a monetary condition which was used by the intermediary to process an institutional claim. DB2 ALIAS: CLM_VAL_CD SAS ALIAS: VAL_CD STANDARD ALIAS: CLM_VAL_CD SYSTEM ALIAS: LTVALUE TITLE ALIAS: VALUE_CD CODES: REFER TO: CLM_VAL_TB IN THE CODES APPENDIX SOURCE: CWF

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
7. Claim Value Amount	CHAR	13	24	36	The amount related to the condition identified in the CLM_VAL_CD which was used by the

intermediary to process the institutional
claim.

9.2 DIGITS SIGNED

DB2 ALIAS: CLM_VAL_AMT
SAS ALIAS: VAL_AMT
STANDARD ALIAS: CLM_VAL_AMT
TITLE ALIAS: VALUE_AMOUNT

EDIT-RULES:
+9(9).99

SOURCE:
CWF

****

C L A I M R E V E N U E C E N T E R G R O U P R E C O R D

****

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	FI Outpatient Claim Revenue Center Group Record - Encrypted Standard View	GROUP	262			Claim Revenue Center Group Record for the Encrypted Standard View of the Outpatient version I Nearline File.

The number of claim revenue center group
trailers present is determined by the claim
revenue center code count. Effective 7/7/00,
up to 450 occurrences may be reported for an
institutional claim. The increase in the number
of revenue center lines causes each claim to
be broken out into records/segments (up to 10).
Each record can have up to 45 occurrences of
revenue center lines. Prior to 7/7/00, up to
58 occurrences may be reported on an institutional
claim. Claims submitted prior to 10/93, contained
up to 28 occurrences.

OCCURS: UP TO 45 TIMES
DEPENDING ON OP_REV_CNTR_CD_I_CNT

STANDARD ALIAS: UTLOUTPI_CLM_REV_CNTR_GRP

COMMENT:
********** FOR SNF PPS **********
The Balanced Budget Act modified how payment will be
made for skilled nursing facility (SNF) services.
Effective with cost reporting periods beginning on or
after 7/1/98 (with all providers transitioning by

FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					6/30/99, SNFs will be paid on a prospective payment system (PPS). SNFs will classify beneficiaries on the basis of residents' characteristics and resource needs, using the 44-group patient classification system known as Resource Utilization Groups (RUGS), Version III. Facilities will use information from the Minimum Data Set (MDS), Version 2.0, Resident Assessment Instrument (RAI) to classify residents into the RUG-III groups. ****************** FOR OUTPATIENT PPS *************** The Balanced Budget Act modified how payment will be made for hospital outpatient services, certain PTB services furnished to inpatients who have no PTA coverage, CMHCs, and limited services provided by CORFs, Home Health Agencies or to hospice patients for the treatment of a non-terminal illness. Imple-
					mentation for Outpatient PPS (OPPS) will be effective for claims with dates of service on or after July 1, 2000. Payment for services under the OPPS system is calculated based on grouping outpatient services into ambulatory payment classifications (APC) groups. ************** FOR HOME HEALTH PPS *************** The Balanced Budget Act of 1997 mandated changes in payment and other provider requirements for home health. All home health agencies will be paid through a prospective payment system beginning October 1, 2000. Under Home Health PPS (HH PPS) the unit of payment will be a 60-day episode. Home Health Resources Groups (HHRGs), also called HRGs represented by HCFA HIPPS coding, will be the basis of payment for each episode; HHRGs will be produced through pubicly available Grouper software that will determine the appropriate HHRG when results of comprehensive assessments of the beneficiary (made incorporating the OASIS data set) are input or grouped in this software.
1. Record Length Count	NUM	5	1	5	The length of the Claim Revenue Center Group Record. 5 DIGITS UNSIGNED STANDARD ALIAS: TRAIL_BYTE_COUNT

2. Record Number	NUM	9	6	14	An automatically assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim. STANDARD ALIAS: TRAIL_CLAIM_NO
3. Record Type	NUM	2	15	16	Type of Record. STANDARD ALIAS: TRAIL_REC_TYPE CODES: 00 = Fixed/Main Group 01 = Carrier Line Group 02 = Claim Demonstration ID Group 03 = Claim Diagnosis Group 04 = Claim Health PlanID Group 05 = Claim Occurrence Span Group 06 = Claim Procedure Group 07 = Claim Related Condition Group

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					08 = Claim Related Occurrence Group 09 = Claim Value Group 10 = MCO Period Group 11 = NCH Edit Group 12 = NCH Patch Group 13 = DMERC Line Group 14 = Revenue Center Group
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim. STANDARD ALIAS: TRAIL_CLAIM_SEQ
5. NCH Claim Type Code	CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH. NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991). NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added. STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD DERIVATION: FFS CLAIM TYPE CODES DERIVED FROM: NCH CLM_NEAR_LINE_RIC_CD

FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					NCH PMT_EDIT_RIC_CD NCH CLM_TRANS_CD NCH PRVDR_NUM INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (Pre-HDC processing -- AVAILABLE IN NCH) CLM_MCO_PD_SW CLM_RLT_COND_CD MCO_CNTRCT_NUM MCO_OPTN_CD MCO_PRD_EFCTV_DT MCO_PRD_TRMNTN_DT INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD)
					FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD. PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) CARR_NUM CLM_DEMO_ID_NUM OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD DERIVATION RULES: SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U' 2. PMT_EDIT_RIC_CD EQUAL 'F' 3. CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
CLSFCTN_TYPE_CD = '2', '3' OR '4' &
CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
   MCO_OPTN_CD = 'C'
   CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
   MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
   ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
   TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)

1 FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one or
   more line item(s) match the HCPCS on the
   DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
CONDITIONS ARE MET:
1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD on DMEPOS table (NOTE: if one or

more line item(s) match the HCPCS on the
DMEPOS table).

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

COMMENT:
Prior to Version H this field was named:
CLM_OTHR_DGNS_CD.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
6. Revenue Center Code	CHAR	4	22	25	The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim. COBOL ALIAS: REV_CD DB2 ALIAS: REV_CNTR_CD SAS ALIAS: REV_CNTR STANDARD ALIAS: REV_CNTR_CD

SYSTEM ALIAS: LTRC
TITLE ALIAS: REVENUE_CENTER_CD

CODES:
REFER TO: REV_CNTR_TB
IN THE CODES APPENDIX

SOURCE:
CWF

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
7. Revenue Center Date	NUM	8	26	33	Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS. For the ENCRYPTED Standard View of the Outpatient files, the date applicable to the service represented by the revenue center code is coded as the quarter of the calendar year when the service represented by the revenue

center code occurred.

NOTE1: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

NOTE2: When revenue center code equals '0022' (SNF PPS) and revenue center HCPCS code not equal to 'AAA00' (default for no assessment), date represents the MDS RAI assessment reference date.

NOTE3: When revenue center code equals '0023' (HHPPS), the date on the initial claim (RAP) must represent the first date of service in the episode. The final claim will match the '0023' information submitted on the initial claim. The SCIC (significant change in condition) claims may show additional '0023' revenue lines in which the date represents the date of the first service under the revised plan of treatment.

8 DIGITS UNSIGNED

DB2 ALIAS: REV_CNTR_DT
SAS ALIAS: REV_DT
STANDARD ALIAS: REV_CNTR_DT
TITLE ALIAS: REV_CNTR_DATE

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						EDIT-RULES FOR ENCRYPTED DATA: YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES. 1 = FIRST QUARTER OF THE CALENDAR YEAR 2 = SECOND QUARTER OF THE CALENDAR YEAR 3 = THIRD QUARTER OF THE CALENDAR YEAR 4 = FOURTH QUARTER OF THE CALENDAR YEAR SOURCE: CWF
8.	Revenue Center APC/HIPPS Code	CHAR	5	34	38	Effective with Outpatient PPS (OPPS), the Ambulatory Payment Classification (APC) code used to identify groupings of outpatient services. APC codes are used to calculate payment for services under OPPS. Effective with Home Health PPS (HHPPS), this field will only be populated with a HIPPS code if the HIPPS code that is stored in the HCPCS field has been downcoded and the new code will be placed in this field.

NOTE1: Under SNF PPS and HHPPS, HIPPS codes are stored in the HCPCS field. **EXCEPTION: if a HHPPS HIPPS code is downcoded the downcoded HIPPS will be stored in this field.

NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV_APC_HIPPS_CD
SAS ALIAS: APCHIPPS
STANDARD ALIAS: REV_CNTR_APC_HIPPS_CD
SYSTEM ALIAS: LTAPC
TITLE ALIAS: APC_HIPPS

CODES:
REFER TO: REV_CNTR_APC_TB
IN THE CODES APPENDIX

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
9.	Revenue Center HCFA Common Procedure Coding System Code	CHAR	5	39	43	HCFA's Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below:

DB2 ALIAS: REV_CNTR_HCPCS_CD
SAS ALIAS: HCPCS_CD
STANDARD ALIAS: REV_CNTR_HCPCS_CD
SYSTEM ALIAS: LTHIPPS
TITLE ALIAS: HCPCS_CD

CODES:
REFER TO: CLM_HIPPS_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
HCPCS_CD. With Version H, a prefix
was added to denote the location of this field
on each claim type (institutional: REV_CNTR and
non-institutional: LINE).

NOTE: When revenue center code = '0022' (SNF PPS) or '0023' (HH PPS), this field contains the Health Insurance PPS (HIPPS) code. The HIPPS code for

SNF PPS contains the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode.

For both SNF PPS & HH PPS HIPPS values see CLM_HIPPS_TB.

Level I
Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services.

**** Note: ****
CPT-4 codes including both long and short descriptions shall be used in accordance with the HCFA/AMA agreement. Any other use violates the AMA copyright.

Level II
Includes codes and descriptors copyrighted by the American Dental Association's Current Dental

1 FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

Level III
Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not

represented in the level I or level II codes.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
10.	Revenue Center HCPCS Initial Modifier Code	CHAR	2	44	45	A first modifier to the procedure code to enable a more specific procedure identification for the claim. DB2 ALIAS: REV_HCPCS_MDFR_CD SAS ALIAS: MDFR_CD1 STANDARD ALIAS: REV_CNTR_HCPCS_INITL_MDFR_CD TITLE ALIAS: INITIAL_MODIFIER EDIT-RULES: Carrier Information File COMMENT: Prior to Version H this field was named: HCPCS_INITL_MDFR_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV_CNTR and non-institutional: LINE). SOURCE: CWF
11.	Revenue Center HCPCS Second Modifier Code	CHAR	2	46	47	A second modifier to the procedure code to make it more specific than the first modifier code to identify the procedures performed on the beneficiary for the claim. DB2 ALIAS: REV_HCPCS_2ND_CD SAS ALIAS: MDFR_CD2 STANDARD ALIAS: REV_CNTR_HCPCS_2ND_MDFR_CD TITLE ALIAS: SECOND_MODIFIER EDIT-RULES: CARRIER INFORMATION FILE

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						COMMENT: Prior to Version H this field was named: HCPCS_2ND_MDFR_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV_CNTR and non-institutional: LINE). SOURCE: CWF
12.	Revenue Center HCPCS Third Modifier Code	CHAR	2	48	49	Effective with Version I, a third modifier to the procedure code to make it more specific than the second modifier code to identify the procedures performed on the beneficiary for the claim. DB2 ALIAS: REV_HCPCS_3RD_CD SAS ALIAS: MDFR_CD3

STANDARD ALIAS: REV_CNTR_HCPCS_3RD_MDFR_CD
TITLE ALIAS: THIRD_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE

COMMENT:
NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
13.	Revenue Center HCPCS Fourth Modifier Code	CHAR	2	50	51	Effective with Version I, a fourth modifier to the procedure code to make it more specific than the third modifier code to identify the procedures performed on the beneficiary for the claim. DB2 ALIAS: REV_HCPCS_4TH_CD SAS ALIAS: MDFR_CD4 STANDARD ALIAS: REV_CNTR_HCPCS_4TH_MDFR_CD TITLE ALIAS: FOURTH_MODIFIER EDIT-RULES: CARRIER INFORMATION FILE COMMENT: NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field. SOURCE: CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
14.	Revenue Center HCPCS Fifth Modifier Code	CHAR	2	52	53	Effective with Version I, a fifth modifier to the procedure code to make it more specific than the fourth modifier code to identify the procedures performed on the beneficiary for the claim. DB2 ALIAS: REV_HCPCS_5TH_CD SAS ALIAS: MDFR_CD5 STANDARD ALIAS: REV_CNTR_HCPCS_5TH_MDFR_CD TITLE ALIAS: FIFTH_MODIFIER EDIT-RULES: CARRIER INFORMATION FILE COMMENT: NOTE: Beginning with NCH weekly process date

8/18/00, this field will be populated with data.
Claims processed prior to 8/18/00 will contain
spaces in this field.

SOURCE:
CWF

15. Revenue Center Payment Method Indicator Code	CHAR	2	54	55	Effective with Version 'I', the code used to identify how the service is priced for payment. This field is made up of two pieces of data, 1st position being the service indicator and the 2nd position being the payment indicator. NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field. DB2 ALIAS: REV_PMT_MTHD_CD SAS ALIAS: PMTMTHD STANDARD ALIAS: REV_CNTR_PMT_MTHD_IND_CD SYSTEM ALIAS: LTPMTHD TITLE ALIAS: PMT_MTHD CODES: REFER TO: REV_CNTR_PMT_MTHD_IND_TB IN THE CODES APPENDIX SOURCE: CWF
16. Revenue Center Discount Indicator Code	CHAR	1	56	56	Effective with Version 'I', for all services subject to Outpatient PPS, this code represents a factor that specifies the amount of any APC discount. The discounting factor is applied to a line item with a service indicator (part of the REV_CNTR_PMT_MTHD_IND_CD) of 'T'. The flag is applicable when more than one significant procedure is performed. **If there is no dis-counting the factor will be 1.0.**

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					NOTE1: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field. DB2 ALIAS: REV_DSCNT_IND_CD SAS ALIAS: DSCNTIND STANDARD ALIAS: REV_CNTR_DSCNT_IND_CD SYSTEM ALIAS: LTDSCNT TITLE ALIAS: REV_CNTR_DSCNT_IND_CD

CODES:
DISCOUNTING FORMULAS
1 = 1.0
2 = (1.0+D(U-1))/U
3 = T/U
4 = (1+D)/U
5 = D
6 = TD/U
7 = D(1+D)/U
8 = 2.0/U

SOURCE:
CWF

17. Revenue Center Packaging Indicator Code — CHAR, 1, 57, 57

Effective with Version 'I', for all services subject to Outpatient PPS, the code used to identify those services that are packaged/ bundled with another service.

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV_PACKG_IND_CD
SAS ALIAS: PACKGIND
STANDARD ALIAS: REV_CNTR_PACKG_IND_CD
SYSTEM ALIAS: LTPACKG
TITLE ALIAS: REV_CNTR_PACKG_IND

CODES:
0 = Not packaged
1 = Packaged service (service indicator N)
2 = Packaged as part of partial hospitalization per diem or daily mental health service per diem

SOURCE:
CWF

18. Revenue Center Pricing Indicator Code — CHAR, 2, 58, 59

Effective with Version 'I', the code used to identify if there was a deviation from

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

the standard method of calculating payment amount.

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV_PRICNG_IND_CD
SAS ALIAS: PRICNG

					STANDARD ALIAS: REV_CNTR_PRICNG_IND_CD SYSTEM ALIAS: LTPRICNG TITLE ALIAS: REV_CNTR_PRICNG_IND CODES: REFER TO: REV_CNTR_PRICNG_IND_TB IN THE CODES APPENDIX SOURCE: CWF
19.	Revenue Center Obligation to Accept As Full (OTAF) Payment Code	CHAR	1	60	60	Effective with Version 'I' the code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer. NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. DB2 ALIAS: REV_OTAF1_IND_CD SAS ALIAS: OTAF_1 STANDARD ALIAS: REV_CNTR_OTAF_1_IND_CD TITLE ALIAS: REV_CNTR_OTAF_1_IND_CD EDIT-RULES: Y = provider is obligated to accept the payment as payment in full for the service. N or blank = provider is not obligated to accept the payment, or there is no payment by a prior payer. SOURCE: CWF
20.	Revenue Center IDE, NDC, UPC Number	CHAR	24	61	84	Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. CMS established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					dates beginning 10/1/95. IDE's are always associated with revenue center code '0624'. NOTE1: Prior to Version H a 'dummy' revenue center code '0624' trailer was created to store IDE's. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second

modifier contained the value 'ID'. There can be up to 7 distinct IDE numbers associated with an '0624' dummy trailer. During the Version H conversion IDE's were moved from the dummy '0624' trailer to this dedicated field.

NOTE2: Effective with Version 'I', this field was renamed to eventually accommodate the National Drug Code (NDC) and the Universal Product Code (UPC). This field could contain either of these 3 fields (there would never be an instance where more than one would come in on a claim). The size of this field was expanded to X(24) to accommodate either of the new fields (under Version 'H' it was X(7). DATA ANAMOLY/LIMITATION: During an CWFMQA review an edit revealed the IDE was missing. The problem occurs in claim with an NCH weekly process dates of 6/9/00 through 9/8/00. During processing of the new format the program receives the IDE but then blanked out the data.

DB2 ALIAS: IDE_NDC_UPC_NUM
SAS ALIAS: IDENDC
STANDARD ALIAS: REV_CNTR_IDE_NDC_UPC_NUM
TITLE ALIAS: IDE_NDC_UPC

SOURCE:
CWF

21. Revenue Center Unit Count	CHAR	8	85	92	A quantitative measure (unit) of the number of times the service or procedure being reported was performed according to the revenue center/HCPCS code definition as described on an institutional claim. Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests. NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code. 7 DIGITS SIGNED

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					DB2 ALIAS: REV_CNTR_UNIT_CNT SAS ALIAS: REV_UNIT STANDARD ALIAS: REV_CNTR_UNIT_CNT TITLE ALIAS: UNITS EDIT-RULES:

					+9(7) SOURCE: CWF
22. Revenue Center Rate Amount	CHAR	13	93	105	Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, $1 will be reported in the field. NOTE1: For SNF PPS claims (when revenue center code equals '0022'), HCFA has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field). NOTE2: For OP PPS claims, HCFA has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index. NOTE3: Under HH PPS (when revenue center code equals '0023'), HCFA has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode. On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment. In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level. 9.2 DIGITS SIGNED DB2 ALIAS: REV_CNTR_RATE_AMT SAS ALIAS: REV_RATE STANDARD ALIAS: REV_CNTR_RATE_AMT TITLE ALIAS: CHARGE_PER_UNIT

			POSITIONS		
NAME	TYPE	LENGTH	BEG	END	CONTENTS
					EDIT-RULES: +9(9).99 EFFECTIVE-DATE: 10/01/1993

					COMMENT: Prior to Version H the size of this field was: S9(7)V99. SOURCE: CWF
23.	Revenue Center Blood Deductible Amount	CHAR	13	106 118	Effective with Version 'I', the amount of money for which the intermediary determined the beneficiary is liable for the blood deductible for the line item service. NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_BLOOD_DDCTBL SAS ALIAS: REVBLOOD STANDARD ALIAS: REV_CNTR_BLOOD_DDCTBL_AMT TITLE ALIAS: BLOOD_DDCTBL_AMT EDIT-RULES: +9(9).99 SOURCE: CWF
24.	Revenue Center Cash Deductible Amount	CHAR	13	119 131	Effective with Version 'I' the amount of cash deductible the beneficiary paid for the line item service. NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_CASH_DDCTBL SAS ALIAS: REVDCTBL STANDARD ALIAS: REV_CNTR_CASH_DDCTBL_AMT TITLE ALIAS: CASH_DDCTBL EDIT-RULES: +9(9).99

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
						SOURCE: CWF

25. Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount	CHAR	13	132	144	Effective with Version 'I', the amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted. NOTE1: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification. NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: ADJSTD_COINSRNC SAS ALIAS: WAGEADJ STANDARD ALIAS: REV_CNTR_WAGE_ADJSTD_COINS_AMT TITLE ALIAS: WAGE_ADJSTD_COINS EDIT-RULES: +9(9).99 SOURCE: CWF
26. Revenue Center Reduced Coinsurance Amount	CHAR	13	145	157	Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to the line for a particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount. NOTE1: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line. NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					9.2 DIGITS SIGNED

DB2 ALIAS: RDCD_COINSRNC
SAS ALIAS: RDCDCOIN
STANDARD ALIAS: REV_CNTR_RDCD_COINS_AMT
TITLE ALIAS: REDUCED_COINS

EDIT-RULES:
+9(9).99

SOURCE:
CWF

27. Revenue Center 1st Medicare Secondary Payer Paid Amount — CHAR, 13, 158, 170

Effective with Version 'I', the amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary or tertiary).

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_MSP1_PD_AMT
SAS ALIAS: REV_MSP1
STANDARD ALIAS: REV_CNTR_MSP1_PD_AMT
TITLE ALIAS: MSP PAID AMOUNT

EDIT-RULES:
+9(9).99

SOURCE:
CWF

28. Revenue Center 2nd Medicare Secondary Payer Paid Amount — CHAR, 13, 171, 183

Effective with Version 'I', the amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_MSP2_PD_AMT
SAS ALIAS: REV_MSP2
STANDARD ALIAS: REV_CNTR_MSP2_PD_AMT
TITLE ALIAS: MSP PAID AMOUNT

EDIT-RULES:
+9(9).99

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

						SOURCE: CWF
29.	Revenue Center Provider Payment Amount	CHAR	13	184	196	Effective with Version 'I', the amount paid to the provider for the services reported on the line item. NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_PRVDR_PMT_AMT SAS ALIAS: RPRVDPMT STANDARD ALIAS: REV_CNTR_PRVDR_PMT_AMT TITLE ALIAS: REV_PRVDR_PMT EDIT-RULES: +9(9).99 SOURCE: CWF
30.	Revenue Center Beneficiary Payment Amount	CHAR	13	197	209	Effective with Version I, the amount paid to the beneficiary for the services reported on the line item. NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_BENE_PMT_AMT SAS ALIAS: RBENEPMT STANDARD ALIAS: REV_CNTR_BENE_PMT_AMT TITLE ALIAS: REV_BENE_PMT EDIT-RULES: +9(9).99 SOURCE: CWF
31.	Revenue Center Patient Responsibility Payment Amount	CHAR	13	210	222	Effective with Version I, the amount paid by the beneficiary to the provider for the line item service. NOTE: Beginning with NCH weekly process date 7/7/00 this field was populated with data.

NAME	TYPE	LENGTH	BEG	END	CONTENTS
					Claims processed prior to 7/7/00 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_PTNT_RESP_AMT SAS ALIAS: PTNTRESP STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT TITLE ALIAS: REV_PTNT_RESP EDIT-RULES: +9(9).99 SOURCE: CWF
32. Revenue Center Payment Amount	CHAR	13	223	235	Effective with Version 'I', the line item Medicare payment amount for the specific revenue center. Under OP PPS, PRICER will compute the standard OPPS payment for a line item based on the payment APC. Under HH PPS, PRICER will compute/return a line item payment amount for the case-mixed, wage-index adjusted HIPPS code assigned to the '0023' revenue center line. The HIPPS code will be stored in the Revenue Center HCPCS code field. 9.2 DIGITS SIGNED COMMON ALIAS: REIMBURSEMENT DB2 ALIAS: REV_CNTR_PMT_AMT SAS ALIAS: REVPMT STANDARD ALIAS: REV_CNTR_PMT_AMT TITLE ALIAS: REIMBURSEMENT EDIT-RULES: +9(9).99 SOURCE: CWF
33. Revenue Center Total Charge Amount	CHAR	13	236	248	The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days).

NAME	TYPE	LENGTH	BEG	END	CONTENTS
					EXCEPTIONS: (1) For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo). (2) For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero. (3) For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line. (4) For Home Health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023'). (5) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be $1 (rate) times units (days). 9.2 DIGITS SIGNED DB2 ALIAS: REV_TOT_CHRG_AMT SAS ALIAS: REV_CHRG STANDARD ALIAS: REV_CNTR_TOT_CHRG_AMT TITLE ALIAS: REVENUE_CENTER_CHARGES EDIT-RULES: +9(9).99 COMMENT: Prior to Version H the size of this field was: S9(7)V99. SOURCE: CWF
34. Revenue Center Non-Covered Charge Amount	CHAR	13	249	261	The charge amount related to a revenue center code for services that are not covered by Medicare. NOTE: Prior to Version H the field size was S9(7)V99 and the element was only present on the Inpatient/SNF format. As of NCH weekly process date 10/3/97 this field was added to all institutional claim types. 9.2 DIGITS SIGNED DB2 ALIAS: REV_NCVR_CHRG_AMT SAS ALIAS: REV_NCVR STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT TITLE ALIAS: REV_CENTER_NONCOVERED_CHARGES

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						EDIT-RULES: +9(9).99 SOURCE: CWF
35.	Revenue Center Deductible Coinsurance Code	CHAR	1	262	262	Code indicating whether the revenue center charges are subject to deductible and/or coinsurance. DB2 ALIAS: DDCTBL_COINSRNC_CD SAS ALIAS: REVDEDCD STANDARD ALIAS: REV_CNTR_DDCTBL_COINSRNC_CD TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD CODES: REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB IN THE CODES APPENDIX SOURCE: CWF Claims processed prior to 8/18/00 will contain spaces in this field.
						DB2 ALIAS: REV_APC_HIPPS_CD SAS ALIAS: APCHIPPS STANDARD ALIAS: REV_CNTR_APC_HIPPS_CD SYSTEM ALIAS: LTAPC TITLE ALIAS: APC_HIPPS CODES: REFER TO: REV_CNTR_APC_TB IN THE CODES APPENDIX SOURCE: CWF

1 BENE_IDENT_TB — Beneficiary Identification Code (BIC) Table

Social Security Administration:

A = Primary claimant
B = Aged wife, age 62 or over (1st claimant)
B1 = Aged husband, age 62 or over (1st claimant)
B2 = Young wife, with a child in her care (1st claimant)
B3 = Aged wife (2nd claimant)
B4 = Aged husband (2nd claimant)

B5 = Young wife (2nd claimant)
B6 = Divorced wife, age 62 or over (1st claimant)
B7 = Young wife (3rd claimant)
B8 = Aged wife (3rd claimant)
B9 = Divorced wife (2nd claimant)
BA = Aged wife (4th claimant)
BD = Aged wife (5th claimant)
BG = Aged husband (3rd claimant)
BH = Aged husband (4th claimant)
BJ = Aged husband (5th claimant)
BK = Young wife (4th claimant)
BL = Young wife (5th claimant)
BN = Divorced wife (3rd claimant)
BP = Divorced wife (4th claimant)
BQ = Divorced wife (5th claimant)
BR = Divorced husband (1st claimant)
BT = Divorced husband (2nd claimant)
BW = Young husband (2nd claimant)
BY = Young husband (1st claimant)
C1-C9,CA-CZ = Child (includes minor, student or disabled child)
D = Aged widow, 60 or over (1st claimant)
D1 = Aged widower, age 60 or over (1st claimant)
D2 = Aged widow (2nd claimant)
D3 = Aged widower (2nd claimant)
D4 = Widow (remarried after attainment of age 60) (1st claimant)
D5 = Widower (remarried after attainment of age 60) (1st claimant)
D6 = Surviving divorced wife, age 60 or over (1st claimant)
D7 = Surviving divorced wife (2nd claimant)
D8 = Aged widow (3rd claimant)
D9 = Remarried widow (2nd claimant)
DA = Remarried widow (3rd claimant)
DC = Surviving divorced husband (1st claimant)
DD = Aged widow (4th claimant)
DG = Aged widow (5th claimant)
DH = Aged widower (3rd claimant)
DJ = Aged widower (4th claimant)
DK = Aged widower (5th claimant)
DL = Remarried widow (4th claimant)
DM = Surviving divorced husband (2nd claimant)
DN = Remarried widow (5th claimant)

1	BENE_IDENT_TB	Beneficiary Identification Code (BIC) Table
	---	---

DP = Remarried widower (2nd claimant)
DQ = Remarried widower (3rd claimant)
DR = Remarried widower (4th claimant)
DS = Surviving divorced husband (3rd claimant)
DT = Remarried widower (5th claimant)
DV = Surviving divorced wife (3rd claimant)
DW = Surviving divorced wife (4th claimant)

DX = Surviving divorced husband (4th
claimant)
DY = Surviving divorced wife (5th claimant)
DZ = Surviving divorced husband (5th
claimant)
E = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st
claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd
claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower)
(1st claimant)
E6 = Father (widower) (2nd claimant)
E7 = Mother (widow) (3rd claimant)
E8 = Mother (widow) (4th claimant)
E9 = Surviving divorced father (widower)
(2nd claimant)
EA = Mother (widow) (5th claimant)
EB = Surviving divorced mother (3rd
claimant)
EC = Surviving divorced mother (4th
claimant)
ED = Surviving divorced mother (5th
claimant
EF = Father (widower) (3rd claimant)
EG = Father (widower) (4th claimant)
EH = Father (widower) (5th claimant)
EJ = Surviving divorced father (3rd
claimant)
EK = Surviving divorced father (4th
claimant)
EM = Surviving divorced father (5th
claimant)
F1 = Father
F2 = Mother
F3 = Stepfather
F4 = Stepmother
F5 = Adopting father
F6 = Adopting mother
F7 = Second alleged father
F8 = Second alleged mother
J1 = Primary prouty entitled to HIB
(less than 3 Q.C.) (general fund)
J2 = Primary prouty entitled to HIB
(over 2 Q.C.) (RSI trust fund)
J3 = Primary prouty not entitled to HIB
(less than 3 Q.C.) (general fund)
J4 = Primary prouty not entitled to HIB

1 BENE_IDENT_TB Beneficiary Identification Code (BIC) Table

(over 2 Q.C.) (RSI trust fund)
K1 = Prouty wife entitled to HIB (less than
3 Q.C.) (general fund) (1st claimant)
K2 = Prouty wife entitled to HIB (over 2
Q.C.) (RSI trust fund) (1st claimant)

K3 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)
K4 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)
K5 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)
K6 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)
K7 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)
K8 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)
K9 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)
KA = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)
KB = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)
KC = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)
KD = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (4th claimant)
KE = Prouty wife entitled to HIB (over 2 Q.C (4th claimant)
KF = Prouty wife not entitled to HIB (less than 3 Q.C.)(4th claimant)
KG = Prouty wife not entitled to HIB (over 2 Q.C.)(4th claimant)
KH = Prouty wife entitled to HIB (less than 3 Q.C.)(5th claimant)
KJ = Prouty wife entitled to HIB (over 2 Q.C.) (5th claimant)
KL = Prouty wife not entitled to HIB (less than 3 Q.C.)(5th claimant)
KM = Prouty wife not entitled to HIB (over 2 Q.C.) (5th claimant)
M = Uninsured-not qualified for deemed HIB
M1 = Uninsured-qualified but refused HIB
T = Uninsured-entitled to HIB under deemed or renal provisions
TA = MQGE (primary claimant)
TB = MQGE aged spouse (first claimant)
TC = MQGE disabled adult child (first claimant)
TD = MQGE aged widow(er) (first claimant)
TE = MQGE young widow(er) (first claimant)
TF = MQGE parent (male)
TG = MQGE aged spouse (second claimant)

1 BENE_IDENT_TB — Beneficiary Identification Code (BIC) Table

TH = MQGE aged spouse (third claimant)
TJ = MQGE aged spouse (fourth claimant)

TK = MQGE aged spouse (fifth claimant)
TL = MQGE aged widow(er) (second claimant)
TM = MQGE aged widow(er) (third claimant)
TN = MQGE aged widow(er) (fourth claimant)
TP = MQGE aged widow(er) (fifth claimant)
TQ = MQGE parent (female)
TR = MQGE young widow(er) (second claimant)
TS = MQGE young widow(er) (third claimant)
TT = MQGE young widow(er) (fourth claimant)
TU = MQGE young widow(er) (fifth claimant)
TV = MQGE disabled widow(er) fifth claimant
TW = MQGE disabled widow(er) first claimant
TX = MQGE disabled widow(er) second claimant
TY = MQGE disabled widow(er) third claimant
TZ = MQGE disabled widow(er) fourth claimant
T2-T9 = Disabled child (second to ninth claimant)
W = Disabled widow, age 50 or over (1st claimant)
W1 = Disabled widower, age 50 or over (1st claimant)
W2 = Disabled widow (2nd claimant)
W3 = Disabled widower (2nd claimant)
W4 = Disabled widow (3rd claimant)
W5 = Disabled widower (3rd claimant)
W6 = Disabled surviving divorced wife (1st claimant)
W7 = Disabled surviving divorced wife (2nd claimant)
W8 = Disabled surviving divorced wife (3rd claimant)
W9 = Disabled widow (4th claimant)
WB = Disabled widower (4th claimant)
WC = Disabled surviving divorced wife (4th claimant)
WF = Disabled widow (5th claimant)
WG = Disabled widower (5th claimant)
WJ = Disabled surviving divorced wife (5th claimant)
WR = Disabled surviving divorced husband (1st claimant)
WT = Disabled surviving divorced husband (2nd claimant)

Railroad Retirement Board:

NOTE:
Employee: a Medicare beneficiary who is still working or a worker who died before retirement
Annuitant: a person who retired under the railroad retirement act on or after 03/01/37
Pensioner: a person who retired prior to 03/01/37 and was included in the railroad retirement act

1 BENE_IDENT_TB — Beneficiary Identification Code (BIC) Table

10 = Retirement - employee or annuitant
80 = RR pensioner (age or disability)
14 = Spouse of RR employee or annuitant
(husband or wife)
84 = Spouse of RR pensioner
43 = Child of RR employee
13 = Child of RR annuitant
17 = Disabled adult child of RR annuitant
46 = Widow/widower of RR employee
16 = Widow/widower of RR annuitant
86 = Widow/widower of RR pensioner
43 = Widow of employee with a child in her care
13 = Widow of annuitant with a child in her care
83 = Widow of pensioner with a child in her care
45 = Parent of employee
15 = Parent of annuitant
85 = Parent of pensioner
11 = Survivor joint annuitant
(reduced benefits taken to insure benefits
for surviving spouse)

1 BENE_PRMRY_PYR_TB — Beneficiary Primary Payer Table

A = Working aged bene/spouse with employer
group health plan (EGHP)
B = End stage renal disease (ESRD) beneficiary
in the 18 month coordination period with
an employer group health plan
C = Conditional payment by Medicare; future
reimbursement expected
D = Automobile no-fault (eff. 4/97; Prior
to 3/94, also included any liability
insurance)
E = Workers' compensation
F = Public Health Service or other federal
agency (other than Dept. of Veterans
Affairs)
G = Working disabled bene (under age 65
with LGHP)
H = Black Lung
I = Dept. of Veterans Affairs
J = Any liability insurance
(eff. 3/94 - 3/97)
L = Any liability insurance (eff. 4/97)
(eff. 12/90 for carrier claims and 10/93
for FI claims; obsoleted for all claim
types 7/1/96)

M = Override code: EGHP services involved
(eff. 12/90 for carrier claims and 10/93
for FI claims; obsoleted for all claim
types 7/1/96)

N = Override code: non-EGHP services involved

(eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)

BLANK = Medicare is primary payer (not sure of effective date: in use 1/91, if not earlier)

T = MSP cost avoided - IEQ contractor (eff. 7/96 carrier claims only)
U = MSP cost avoided - HMO rate cell adjustment contractor (eff. 7/96 carrier claims only)
V = MSP cost avoided - litigation settlement contractor (eff. 7/96 carrier claims only)

X = MSP cost avoided override code (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)

Prior to 12/90

Y = Other secondary payer investigation shows Medicare as primary payer

1 BENE_PRMRY_PYR_TB — Beneficiary Primary Payer Table

Z = Medicare is primary payer

NOTE: Values C, M, N, Y, Z and BLANK indicate Medicare is primary payer. (values Z and Y were used prior to 12/90. BLANK was suppose to be effective after 12/90, but may have been used prior to that date.)

1 BETOS_TB — BETOS Table

M1A = Office visits - new
M1B = Office visits - established
M2A = Hospital visit - initial
M2B = Hospital visit - subsequent
M2C = Hospital visit - critical care
M3 = Emergency room visit
M4A = Home visit
M4B = Nursing home visit
M5A = Specialist - pathology
M5B = Specialist - psychiatry
M5C = Specialist - opthamology
M5D = Specialist - other
M6 = Consultations
P0 = Anesthesia
P1A = Major procedure - breast
P1B = Major procedure - colectomy

P1C = Major procedure - cholecystectomy
P1D = Major procedure - turp
P1E = Major procedure - hysterctomy
P1F = Major procedure - explor/decompr/excisdisc
P1G = Major procedure - Other
P2A = Major procedure, cardiovascular-CABG
P2B = Major procedure, cardiovascular-Aneurysm repair
P2C = Major Procedure, cardiovascular-Thromboendarterectomy
P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA)
P2E = Major procedure, cardiovascular-Pacemaker insertion
P2F = Major procedure, cardiovascular-Other
P3A = Major procedure, orthopedic - Hip fracture repair
P3B = Major procedure, orthopedic - Hip replacement
P3C = Major procedure, orthopedic - Knee replacement
P3D = Major procedure, orthopedic - other
P4A = Eye procedure - corneal transplant
P4B = Eye procedure - cataract removal/lens insertion
P4C = Eye procedure - retinal detachment
P4D = Eye procedure - treatment
P4E = Eye procedure - other
P5A = Ambulatory procedures - skin
P5B = Ambulatory procedures - musculoskeletal
P5C = Ambulatory procedures - inguinal hernia repair
P5D = Ambulatory procedures - lithotripsy
P5E = Ambulatory procedures - other
P6A = Minor procedures - skin
P6B = Minor procedures - musculoskeletal
P6C = Minor procedures - other (Medicare fee schedule)
P6D = Minor procedures - other (non-Medicare fee schedule)
P7A = Oncology - radiation therapy
P7B = Oncology - other
P8A = Endoscopy - arthroscopy
P8B = Endoscopy - upper gastrointestinal
P8C = Endoscopy - sigmoidoscopy
P8D = Endoscopy - colonoscopy
P8E = Endoscopy - cystoscopy
P8F = Endoscopy - bronchoscopy
P8G = Endoscopy - laparoscopic cholecystectomy
P8H = Endoscopy - laryngoscopy
P8I = Endoscopy - other
P9A = Dialysis services

1 BETOS_TB BETOS Table

--- --- ---

I1A = Standard imaging - chest
I1B = Standard imaging - musculoskeletal
I1C = Standard imaging - breast
I1D = Standard imaging - contrast gastrointestinal
I1E = Standard imaging - nuclear medicine
I1F = Standard imaging - other
I2A = Advanced imaging - CAT: head
I2B = Advanced imaging - CAT: other
I2C = Advanced imaging - MRI: brain
I2D = Advanced imaging - MRI: other
I3A = Echography - eye
I3B = Echography - abdomen/pelvis
I3C = Echography - heart
I3D = Echography - carotid arteries

I3E = Echography - prostate, transrectal
I3F = Echography - other
I4A = Imaging/procedure - heart including cardiac
catheter
I4B = Imaging/procedure - other
T1A = Lab tests - routine venipuncture (non Medicare
fee schedule)
T1B = Lab tests - automated general profiles
T1C = Lab tests - urinalysis
T1D = Lab tests - blood counts
T1E = Lab tests - glucose
T1F = Lab tests - bacterial cultures
T1G = Lab tests - other (Medicare fee schedule)
T1H = Lab tests - other (non-Medicare fee schedule)
T2A = Other tests - electrocardiograms
T2B = Other tests - cardiovascular stress tests
T2C = Other tests - EKG monitoring
T2D = Other tests - other
D1A = Medical/surgical supplies
D1B = Hospital beds
D1C = Oxygen and supplies
D1D = Wheelchairs
D1E = Other DME
D1F = Orthotic devices
O1A = Ambulance
O1B = Chiropractic
O1C = Enteral and parenteral
O1D = Chemotherapy
O1E = Other drugs
O1F = Vision, hearing and speech services
O1G = Influenza immunization
Y1 = Other - Medicare fee schedule
Y2 = Other - non-Medicare fee schedule
Z1 = Local codes
Z2 = Undefined codes

1 CARR_CLM_PMT_DNL_TB Carrier Claim Payment Denial Table
---

0 = Denied
1 = Physician/supplier
2 = Beneficiary
3 = Both physician/supplier and beneficiary
4 = Hospital (hospital based physicians)
5 = Both hospital and beneficiary
6 = Group practice prepayment plan
7 = Other entries (e.g. Employer, union)
8 = Federally funded
9 = PA service
A = Beneficiary under limitation of
liability
B = Physician/supplier under limitation of
liability
D = Denied due to demonstration involvement
(eff. 5/97)
E = MSP cost avoided IRS/SSA/HCFA Data
Match (eff. 7/3/00)

F = MSP cost avoided HMO Rate Cell
(eff. 7/3/00)
G = MSP cost avoided Litigation Settlement
(eff. 7/3/00)
H = MSP cost avoided Employer Voluntary
Reporting (eff. 7/3/00)
J = MSP cost avoided Insurer Voluntary
Reporting (eff. 7/3/00)
K = MSP cost avoided Initial Enrollment
Questionnaire (eff. 7/3/00)
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided - (Contractor #88888)
voluntary agreement (eff. 1/98)
T = MSP cost avoided - IEQ contractor
(eff. 7/96) (obsolete 6/30/00)
U = MSP cost avoided - HMO rate cell
adjustment (eff. 7/96) (obsolete 6/30/00)
V = MSP cost avoided - litigation
settlement (eff. 7/96) (obsolete 6/30/00)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data
match project (obsolete 6/30/00)

1 CARR_LINE_PRVDR_TYPE_TB Carrier Line Provider Type Table

For Physician/Supplier (RIC O) Claims:

0 = Clinics, groups, associations,
partnerships, or other entities
1 = Physicians or suppliers reporting as
solo practitioners
2 = Suppliers (other than sole proprietorship)
3 = Institutional provider
4 = Independent laboratories
5 = Clinics (multiple specialties)
6 = Groups (single specialty)
7 = Other entities

For DMERC (RIC M) Claims - PRIOR TO VERSION H:

0 = Clinics, groups, associations,
partnerships, or other entities
for whom the carrier's own ID number
has been assigned.
1 = Physicians or suppliers billing as
solo practitioners for whom SSN's are
shown in the physician ID code field.
2 = Physicians or suppliers billing as
solo practitioners for whom the carrier's
own physician ID code is shown.
3 = Suppliers (other than sole proprietorship)
for whom EI numbers are used in coding the
ID field.
4 = Suppliers (other than sole proprietorship)
for whom the carrier's own code has been
shown.

5 = Institutional providers and
independent laboratories for whom EI
numbers are used in coding the ID field.
6 = Institutional providers and
independent laboratories for whom the
carrier's own ID number is shown.
7 = Clinics, groups, associations, or
partnerships for whom EI numbers
are used in coding the ID field.
8 = Other entities for whom EI numbers
are used in coding the ID field or
proprietorship for whom EI numbers are
used in coding the ID field.

1CARR_LINE_RDCD_PHYSN_ASTNT_TB — Carrier Line Part B Reduced Physician Assistant Table

BLANK = Adjustment situation (where
CLM_DISP_CD equal 3)
0 = N/A
1 = 65%
A) Physician assistants assisting in
surgery
B) Nurse midwives
2 = 75%
A) Physician assistants performing
services in a hospital (other than
assisting surgery)
B) Nurse practitioners and clinical
nurse specialists performing
services in rural areas
C) Clinical social worker services
3 = 85%
A) Physician assistant services for
other than assisting surgery
B) Nurse practitioners services

1 CARR_NUM_TB — Carrier Number Table

00510 = Alabama BS (eff. 1983)
00511 = Georgia - Alabama BS (eff. 1998)
00512 = Mississippi - Alabama BS (eff. 2000)
00520 = Arkansas BS (eff. 1983)
00521 = New Mexico - Arkansas BS (eff. 1998)
00522 = Oklahoma - Arkansas BS (eff. 1998)
00523 = Missouri - Arkansas BS (eff. 1999)
00528 = Louisianna - Arkansas BS (eff. 1984)
00542 = California BS (eff. 1983; term. 1996)
00550 = Colorado BS (eff. 1983; term. 1994)
00570 = Delaware - Pennsylvania BS (eff. 1983;
term. 1997)
00580 = District of Columbia - Pennsylvania BS
(eff. 1983; term. 1997)
00590 = Florida BS (eff. 1983)
00591 = Connecticut - Florida BS (eff. 2000)

00621 = Illinois BS - HCSC (eff. 1983; term. 1998)
00623 = Michigan - Illinois Blue Shield (eff. 1995)
(term. 1998)
00630 = Indiana - Administar (eff. 1983)
00635 = DMERC-B (Administar Federal, Inc.)
(eff. 1993)
00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)
00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)
00650 = Kansas BS (eff. 1983)
00655 = Nebraska - Kansas BS (eff. 1988)
00660 = Kentucky - Administar (eff. 1983)
00690 = Maryland BS (eff. 1983; term. 1994)
00700 = Massachusetts BS (eff. 1983; term. 1997)
00710 = Michigan BS (eff. 1983; term. 1994)
00720 = Minnesota BS (eff. 1983; term. 1995)
00740 = Missouri - BS Kansas City (eff. 1983)
00751 = Montana BS (eff. 1983)
00770 = New Hampshire/Vermont Physician Services
(eff. 1983; term. 1984)
00780 = New Hampshire/Vermont - Massachusetts BS
(eff. 1985; term. 1997)
00801 = New York - Western BS (eff. 1983)
00803 = New York - Empire BS (eff. 1983)
00805 = New Jersey - Empire BS (eff. 3/99)
00811 = DMERC (A) - Western New York BS (eff. 2000)
00820 = North Dakota - North Dakota BS (eff. 1983)
00824 = Colorado - North Dakota BS (eff. 1995)
00825 = Wyoming - North Dakota BS (eff. 1990)
00826 = Iowa - North Dakota BS (eff. 1999)
00831 = Alaska - North Dakota BS (eff. 1998)
00832 = Arizona - North Dakota BS (eff. 1998)
00833 = Hawaii - North Dakota BS (eff. 1998)
00834 = Nevada - North Dakota BS (eff. 1998)
00835 = Oregon - North Dakota BS (eff. 1998)
00836 = Washington - North Dakota BS (eff. 1998)
00860 = New Jersey - Pennsylvania BS (eff. 1988;
term. 1999)
00865 = Pennsylvania BS (eff. 1983)
00870 = Rhode Island BS (eff. 1983)
00880 = South Carolina BS (eff. 1983)
00882 = RRB - South Carolina PGBA (eff. 2000)

1 CARR_NUM_TB Carrier Number Table
---------- --------------------

00885 = DMERC C - Palmetto (eff. 1993)
00900 = Texas BS (eff. 1983)
00901 = Maryland - Texas BS (eff. 1995)
00902 = Delaware - Texas BS (eff. 1998)
00903 = District of Columbia - Texas BS (eff. 1998)
00904 = Virginia - Texas BS (eff. 2000)
00910 = Utah BS (eff. 1983)
00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
00953 = Michigan - Wisconsin Phy Svc (eff. 1999)
00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
00973 = Triple-S, Inc. - Puerto Rico (eff. 1983)
00974 = Triple-S, Inc. - Virgin Islands
01020 = Alaska - AETNA (eff. 1983; term. 1997)

01030 = Arizona - AETNA (eff. 1983; term. 1997)
01040 = Georgia - AETNA (eff. 1988; term. 1997)
01120 = Hawaii - AETNA (eff. 1983; term. 1997)
01290 = Nevada - AETNA (eff. 1983; term. 1997)
01360 = New Mexico - AETNA (eff. 1986; term. 1997)
01370 = Oklahoma - AETNA (eff. 1983; term. 1997)
01380 = Oregon - AETNA (eff. 1983; term. 1997
01390 = Washington - AETNA (eff. 1994; term. 1997)
02050 = California - TOLIC (eff. 1983)
(term. 2000)
03070 = Connecticut General Life Insurance Co.
(eff. 1983; term. 1985)
05130 = Idaho - Connecticut General (eff. 1983)
05320 = New Mexico - Equitable Insurance
(eff. 1983; term. 1985)
05440 = Tennessee - Connecticut General (eff. 1983)
05530 = Wyoming - Equitable Insurance (eff. 1983)
(term. 1989)
05535 = North Carolina - Connecticut General
(eff. 1988)
05655 = DMERC-D - Connecticut General (eff. 1993)
10071 = Railroad Board Travelers (eff. 1983)
(term. 2000)
10230 = Connecticut - Metra Health (eff. 1986)
(term. 2000)
10240 = Minnesota - Metra Health (eff. 1983)
(term. 2000)
10250 = Mississippi - Metra Health (eff. 1983)
(term. 2000)
10490 = Virginia - Metra Health (eff. 1983)
(term. 2000)
10555 = Travelers Insurance Co. (eff. 1993)
(term. 2000)
11260 = Missouri - General American Life
(eff. 1983; term. 1998)
14330 = New York - GHI (eff. 1983)
16360 = Ohio - Nationwide Insurance Co.
16510 = West Virginia - Nationwide Insurance Co.
21200 = Maine - BS of Massachusetts
31140 = California - National Heritage Ins.
31142 = Maine - National Heritage Ins.
31143 = Massachusetts - National Heritage Ins.
31144 = New Hampshire - National Heritage Ins.
31145 = Vermont - National Heritage Ins.

1 CARR_NUM_TB — Carrier Number Table

31146 = So. California - NHIC (eff. 2000)

1 CLM_BILL_TYPE_TB — Claim Bill Type Table

11 = Hospital-inpatient (including Part A)
12 = Hospital-inpatient or home health visits (Part B only)
13 = Hospital-outpatient (HHA-A also) (under OPPS 13X
must be used for ASC claims submitted for OPPS
payment -- eff. 7/00)

14 = Hospital-other (Part B)
15 = Hospital-intermediate care - level I
16 = Hospital-intermediate care - level II
17 = Hospital-intermediate care - level III
18 = Hospital-swing beds
19 = Hospital-reserved for national assignment
21 = SNF-inpatient (including Part A)
22 = SNF-inpatient or home health visits (Part B only)
23 = SNF-outpatient (HHA-A also)
24 = SNF-other (Part B)
25 = SNF-intermediate care - level I
26 = SNF-intermediate care - level II
27 = SNF-intermediate care - level III
28 = SNF-swing beds
29 = SNF-reserved for national assignment
31 = HHA-inpatient (including Part A)
32 = HHA-inpatient or home health visits (Part B only)
33 = HHA-outpatient (HHA-A also)
34 = HHA-other (Part B)
35 = HHA-intermediate care - level I
36 = HHA-intermediate care - level II
37 = HHA-intermediate care - level III
38 = HHA-swing beds
39 = HHA-reserved for national assignment
41 = Religious Nonmedical Health Care Institution (RNHCI)
hospital-inpatient (including Part A) (all references
to Christian Science (CS) is obsolete eff. 8/00 and
replaced with RNHCI)
42 = RNHCI hospital-inpatient or home health visits (Part B only)
43 = RNHCI hospital-outpatient (HHA-A also)
44 = RNHCI hospital-other (Part B)
45 = RNHCI hospital-intermediate care - level I
46 = RNHCI hospital-intermediate care - level II
47 = RNHCI hospital-intermediate care - level III
48 = RNHCI hospital-swing beds
49 = RNHCI hospital-reserved for national assignment
51 = CS extended care-inpatient (including Part A) OBSOLETE
eff. 7/00 - implementation of Religious Nonmedical
Health Care Institutions (RNHCI)
52 = RNHCI extended care-inpatient or home health visits
(Part B only) (eff. 7/00); prior to 7/00 Christian Science (CS)
53 = RNHCI extended care-outpatient (HHA-A also) (eff. 7/00);
prior to 7/00 referenced CS
54 = RNHCI extended care-other (Part B)(eff. 7/00); prior
to 7/00 referenced CS
55 = RNHCI extended care-intermediate care - level I (eff. 7/00)
prior to 7/00 referenced CS
56 = RNHCI extended care-intermediate care - level II (eff. 7/00)
prior to 7/00 referenced CS
57 = RNHCI extended care-intermediate care - level III (eff. 7/00)
prior to 7/00 referenced CS
58 = RNHCI extended care-swing beds (eff. 7/00)

prior to 7/00 referenced CS
59 = RNHCI extended care-reserved for national assignment
(eff. 7/00); prior to 7/00 referenced CS

61 = Intermediate care-inpatient (including Part A)
62 = Intermediate care-inpatient or home health visits (Part B only)
63 = Intermediate care-outpatient (HHA-A also)
64 = Intermediate care-other (Part B)
65 = Intermediate care-intermediate care - level I
66 = Intermediate care-intermediate care - level II
67 = Intermediate care-intermediate care - level III
68 = Intermediate care-swing beds
69 = Intermediate care-reserved for national assignment
71 = Clinic-rural health
72 = Clinic-hospital based or independent renal dialysis facility
73 = Clinic-independent provider based FQHC (eff 10/91)
74 = Clinic-ORF only (eff 4/97);
ORF and CMHC (10/91 - 3/97)
75 = Clinic-CORF
76 = Clinic-CMHC (eff 4/97)
77 = Clinic-reserved for national assignment
78 = Clinic-reserved for national assignment
79 = Clinic-other
81 = Special facility or ASC surgery-hospice (non-hospital based)
82 = Special facility or ASC surgery-hospice (hospital based)
83 = Special facility or ASC surgery-ambulatory surgical center
(Discontinued for Hospitals Subject to Outpatient PPS;
hospitals must use 13X for ASC claims submitted for OPPS
payment -- eff. 7/00)
84 = Special facility or ASC surgery-freestanding birthing center
85 = Special facility or ASC surgery-rural primary care hospital (eff
86 = Special facility or ASC surgery-reserved for national use
87 = Special facility or ASC surgery-reserved for national use
88 = Special facility or ASC surgery-reserved for national use
89 = Special facility or ASC surgery-other
91 = Reserved-inpatient (including Part A)
92 = Reserved-inpatient or home health visits (Part B only)
93 = Reserved-outpatient (HHA-A also)
94 = Reserved-other (Part B)
95 = Reserved-intermediate care - level I
96 = Reserved-intermediate care - level II
97 = Reserved-intermediate care - level III
98 = Reserved-swing beds
99 = Reserved-reserved for national assignment

1 CLM_DISP_TB Claim Disposition Table
---

01 = Debit accepted
02 = Debit accepted (automatic adjustment)
applicable through 4/4/93
03 = Cancel accepted
61 = *Conversion code: debit accepted
62 = *Conversion code: debit accepted
(automatic adjustment)
63 = *Conversion code: cancel accepted

*Used only during conversion period:
1/1/91 - 2/21/91

1 CLM_FAC_TYPE_TB Claim Facility Type Table

---

1 = Hospital
2 = Skilled nursing facility (SNF)
3 = Home health agency (HHA)
4 = Religious Nonmedical (Hospital)
(eff. 8/1/00); prior to 8/00 referenced Christian Science (CS)
5 = Religious Nonmedical (Extended Care)
(eff. 8/1/00); prior to 8/00 referenced CS
6 = Intermediate care
7 = Clinic or hospital-based renal dialysis facility
8 = Special facility or ASC surgery
9 = Reserved

1 CLM_FREQ_TB — Claim Frequency Table

0 = Non-payment/zero claims
1 = Admit thru discharge claim
2 = Interim - first claim
3 = Interim - continuing claim
4 = Interim - last claim
5 = Late charge(s) only claim
6 = Adjustment of prior claim
7 = Replacement of prior claim;
eff 10/93, provider debit
8 = Void/cancel prior claim.
eff 10/93, provider cancel
9 = Final claim -- used in an HH PPS episode to indicate the claim should be processed like debit/ credit adjustment to RAP (initial claim) (eff. 10/00)
A = Admission notice - used when hospice is submitting the HCFA-1450 as an admission notice - hospice NOE only
B = Hospice termination/revocation notice - hospice NOE only (eff 9/93)
C = Hospice change of provider notice - hospice NOE only (eff 9/93)
D = Hospice election void/cancel - hospice NOE only (eff 9/93)
E = Hospice change of ownership - hospice NOE only (eff 1/97)
F = Beneficiary initiated adjustment (eff 10/93)
G = CWF generated adjustment (eff 10/93)
H = HCFA generated adjustment (eff 10/93)
I = Misc adjustment claim (other than PRO or provider) - used to identify a debit adjustment initiated by HCFA or an intermediary - eff 10/93, used to identify intermediary initiated adjustment only
J = Other adjustment request (eff 10/93)

K = OIG initiated adjustment (eff 10/93)
M = MSP adjustment (eff 10/93)
P = Adjustment required by peer review organization (PRO)
X = Special adjustment processing - used for QA editing (eff 8/92)
Z = Hospital Encounter Data alternate submission (TOB '11Z') used for MCO enrollee hospital discharges 7/1/97-12/31/98; not stored in NCH. Exception: Problem in startup months may have resulted in this abbreviated UB-92 being erroneously stored in NCH.

1 CLM_HHA_RFRL_TB — Claim Home Health Referral Table

1 = Physician referral - The patient was admitted upon the recommendation of a personal physician.
2 = Clinic referral - The patient was admitted upon the recommendation of this facility's clinic physician.
3 = HMO referral - The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician.
4 = Transfer from hospital - The patient was admitted as an inpatient transfer from an acute care facility.
5 = Transfer from a skilled nursing facility (SNF) - The patient was admitted as an inpatient transfer from a SNF.
6 = Transfer from another health care facility - The patient was admitted as a transfer from a health care facility other than an acute care facility or SNF.
7 = Emergency room - The patient was admitted upon the recommendation of this facility's emergency room physician.
8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.
9 = Information not available - The means by which the patient was admitted is not known.
A = Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.
B = Transfer from another HHA - Beneficiaries are permitted to transfer from one HHA

to another unrelated HHA under HH PPS.
(eff. 10/00)
C = Readmission to same HHA - If a beneficiary
is discharged from an HHA and then re-
admitted within the original 60-day
episode, the original episode must be
closed early and a new once created.
NOTE: the use of this code will permit
the agency to send a new RAP allowing
all claims to be accepted by Medicare.
(eff. 10/00)

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table

********** SNF PPS HIPPS **********
**********1st 3 positions (RUGS-III group)**********
AAA = Default: No assessment

BA1,BA2,BB1,BB2 = Behavior only problems (e.g.,
physical/verbal abuse)

CA1,CA2,CB1,CB2 = Clinically-complex conditions
CC1,CC2 (e.g., chemo, dialysis)

IA1,IA2,IB1,IB2 = Impaired cognition (e.g., im-
paired cognition (e.g., short-
term memory)

PA1,PA2,PB1,PB2 = Reduced physical functions
PC1,PC2,PD1,PD2
PE1,PE2

RHA,RHB,RHC,RLA = Low/medium/high rehabilitation
RLB,RMA,RMB,RMC

RUA,RUB,RUC,RVA = Very high/ultra high rehabilita-
RVB,RVC tion: highest level

SE1,SE2,SE3 = Extensive services; e.g.; IV feed
trach care

SSA,SSB,SSC = Special care; e.g.; coma, burns

**********Positions 4 & 5 represent HIPPS modifier/********
********** assessment type indicator **********

00 = No assessment completed
01 = Medicare 5-day full assessment/not an initial
admission assessment
02 = Medicare 30-day full assessment
03 = Medicare 60-day full assessment
04 = Medicare 90-day full assessment
05 = Medicare Readmission/Return required assessment
(eff. 10/2000)
07 = Medicare 14-day full or comprehensive assessment/
not an initial admission assessment

08 = Off-cycle Other Medicare Required Assessment (OMRA)
11 = Admission assessment AND Medicare 5-day (or readmission/
return) assessment
17 = Medicare 14-day required assessment AND initial
admission assessment (eff. 10/2000)
18 = OMRA replacing Medicare 5-day required assessment
(eff. 10/2000)
28 = OMRA replacing Medicare 30-day required assessment
(eff. 10/2000)
30 = Off-cycle significant change assessment (outside
assessment window) (eff. 10/2000)
31 = Significant change assessment replaces Medicare
5-day assessment (eff. 10/2000)
32 = Significant change assessment replaces Medicare
30-day assessment

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table	

33 = Significant change assessment replaces Medicare
6--day assessment
34 = Significant change assessment replaces Medicare
90-day assessment
35 = Significant change assessment replaces a Medicare
readmission/return assessment
37 = Significant change assessment replaces Medicare
14-day assessment
38 = OMRA replacing Medicare 60-day required
assessment
40 = Off-cycle significant correction assessment of a
prior assessment (outside assessment window)
(eff. 10/2000)
41 = Significant correction of prior full assessment
replaces a Medicare 5-day assessment
42 = Significant correction of prior full assessment
replaces a Medicare 30-day assessment
43 = Significant correction of prior full assessment
replaces a Medicare 60-day assessment
44 = Significant correction of prior full assessment
replaces a Medicare 90-day assessment
45 = Significant correction of a prior assessment
replaces a readmission/return assessment
(eff. 10/2000)
47 = Significant correction of prior full assessment
replaces a Medicare 14-day required assessment
48 = OMRA replacing Medicare 90-day required assessment
54 = Quarterly review assessment - Medicare 90-day
full assessment
78 = OMRA replacing a Medicare 14-day assessment
(eff. 10/2000)

****
****

**********Claim Home Health PPS HIPPS Table**********
********** KEY **********
Position 1 = 'H'
Position 2 = Clinical (A, B, C, D)

Position 3 = Functional (E, F, G, H, I)
Position 4 = Service (J, K, K, M)
Position 5 = identifies which elements of the code were
computed or derived:
1 = 2nd, 3rd, 4th positions computed
2 = 2nd position derived
3 = 3rd position derived
4 = 4th position derived
5 = 2nd & 3rd positions derived
6 = 3rd & 4th positions derived
7 = 2nd & 4th positions derived
8 = 2nd, 3rd, 4th positions derived
****

HHRG = C0F0S0/Clinical = Min, Functional = Min, Service = Min
HAEJ1
HAEJ2
HAEJ3

1 CLM_HIPPS_TB Claim SNF & HHA Health Insurance PPS Table

HAEJ4
HAEJ5
HAEJ6
HAEJ7
HAEJ8
HHRG = C0F0S1/Clinical = Min, Functional = Min, Service = Low
HAEK1
HAEK2
HAEK3
HAEK4
HAEK5
HAEK6
HAEK7
HAEK8
HHRG = C0F0S2/Clinical = Min, Functional = Min, Service = Mod
HAEL1
HAEL2
HAEL3
HAEL4
HAEL5
HAEL6
HAEL7
HAEL8
HHRG = C0F0S3/Clinical = Min, Functional = Min, Service = High
HAEM1
HAEM2
HAEM3
HAEM4
HAEM5
HAEM6
HAEM7
HAEM8
HHRG = C0F1S0/Clinical = Min, Functional = Low, Service = Min
HAFJ1
HAFJ2
HAFJ3
HAFJ4

HAFJ5
HAFJ6
HAFJ7
HAFJ8
HHRG = C0F1S1/Clinical = Min, Functional = Low, Service = Low
HAFK1
HAFK2
HAFK3
HAFK4
HAFK5
HAFK6
HAFK7
HAFK8
HHRG = C0F1S2/Clinical = Min, Functional = Low, Service = Mod
HAFL1
HAFL2
HAFL3
HAFL4
HAFL5
HAFL6
HAFL7

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table
	---	---	---

HAFL8
HHRG = C0F1S3/Clinical = Min, Functional = Low, Service = High
HAFM1
HAFM2
HAFM3
HAFM4
HAFM5
HAFM6
HAFM7
HAFM8
HHRG = C0F2S0/Clinical = Min, Functional = Mod, Service = Min
HAGJ1
HAGJ2
HAGJ3
HAGJ4
HAGJ5
HAGJ6
HAGJ7
HAGJ8
HHRG = C0F2S1/Clinical = Min, Functional = Mod, Service = Low
HAGK1
HAGK2
HAGK3
HAGK4
HAGK5
HAGK6
HAGK7
HAGK8
HHRG = C0F2S2/Clinical = Min, Functional = Mod, Service = Mod
HAGL1
HAGL2
HAGL3
HAGL4
HAGL5

HAGL6
HAGL7
HAGL8
HHRG = C0F2S3/Clinical = Min, Functional = Mod, Service = High
HAGM1
HAGM2
HAGM3
HAGM4
HAGM5
HAGM6
HAGM7
HAGM8
HHRG = C0F3S0/Clinical = Min, Functional = High, Service = Min
HAHJ1
HAHJ2
HAHJ3
HAHJ4
HAHJ5
HAHJ6
HAHJ7
HAHJ8
HHRG = C0F3S1/Clinical = Min, Functional = High, Service = Low
HAHK1
HAHK2

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table

HAHK3
HAHK4
HAHK5
HAHK6
HAHK7
HAHK8
HHRG = C0F3S2/Clinical = Min, Functional = High, Service = Mod
HAHL1
HAHL2
HAHL3
HAHL4
HAHL5
HAHL6
HAHL7
HAHL8
HHRG = C0F3S3/Clinical = Min, Functional = High, Service = High
HAHM1
HAHM2
HAHM3
HAHM4
HAHM5
HAHM6
HAHM7
HAHM8
HHRG = C0F4S0/Clinical = Min, Functional = Max, Service = Min
HAIJ1
HAIJ2
HAIJ3
HAIJ4
HAIJ5
HAIJ6

HAIJ7
HAIJ8
HHRG = C0F4S1/Clinical = Min, Functional = Max, Service = Low
HAIK1
HAIK2
HAIK3
HAIK4
HAIK5
HAIK6
HAIK7
HAIK8
HHRG = C0F4S2/Clinical = Min, Functional = Max, Service = Mod
HAIL1
HAIL2
HAIL3
HAIL4
HAIL5
HAIL6
HAIL7
HAIL8
HHRG = C0F4S3/Clinical = Min, Functional = Max, Service = High
HAIM1
HAIM2
HAIM3
HAIM4
HAIM5
HAIM6

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table

HAIM7
HAIM8
HHRG = C1F0S0/Clinical = Low, Functional = Min, Service = Min
HBEJ1
HBEJ2
HBEJ3
HBEJ4
HBEJ5
HBEJ6
HBEJ7
HBEJ8
HHRG = C1F0S1/Clinical = Low, Functional = Min, Service = Low
HBEK1
HBEK2
HBEK3
HBEK4
HBEK5
HBEK6
HBEK7
HBEK8
HHRG = C1F0S2/Clinical = Low, Functional = Min, Service = Mod
HBEL1
HBEL2
HBEL3
HBEL4
HBEL5
HBEL6
HBEL7

HBEL8
HHRG = C1F0S3/Clinical = Low, Functional = Min, Service = High
HBEM1
HBEM2
HBEM3
HBEM4
HBEM5
HBEM6
HBEM7
HBEM8
HHRG = C1F1S0/Clinical = Low, Functional = Low, Service = Min
HBFJ1
HBFJ2
HBFJ3
HBFJ4
HBFJ5
HBFJ6
HBFJ7
HBFJ8
HHRG = C1F1S1/Clinical = Low, Functional = Low, Service = Low
HBFK1
HBFK2
HBFK3
HBFK4
HBFK5
HBFK6
HBFK7
HBFK8
HHRG = C1F1S2/Clinical = Low, Functional = Low, Service = Mod
HBFL1

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table
	----------	----------	----------

HBFL2
HBFL3
HBFL4
HBFL5
HBFL6
HBFL7
HBFL8
HHRG = C1F1S3/Clinical = Low, Functional = Low, Service = High
HBFM1
HBFM2
HBFM3
HBFM4
HBFM5
HBFM6
HBFM7
HBFM8
HHRG = C1F2S0/Clinical = Low, Functional = Mod, Service = Min
HBGJ1
HBGJ2
HBGJ3
HBGJ4
HBGJ5
HBGJ6
HBGJ7
HBGJ8

HHRG = C1F2S1/Clinical = Low, Functional = Mod, Service = Low
HBGK1
HBGK2
HBGK3
HBGK4
HBGK5
HBGK6
HBGK7
HBGK8
HHRG = C1F2S2/Clinical = Low, Functional = Mod, Service = Mod
HBGL1
HBGL2
HBGL3
HBGL4
HBGL5
HBGL6
HBGL7
HBGL8
HHRG = C1F2S3/Clinical = Low, Functional = Mod, Service = High
HBGM1
HBGM2
HBGM3
HBGM4
HBGM5
HBGM6
HBGM7
HBGM8
HHRG = C1F3S0/Clinical = Low, Functional = High, Service = Min
HBHJ1
HBHJ2
HBHJ3
HBHJ4
HBHJ5

1 CLM_HIPPS_TB Claim SNF & HHA Health Insurance PPS Table

HBHJ6
HBHJ7
HBHJ8
HHRG = C1F3S1/Clinical = Low, Functional = High, Service = Low
HBHK1
HBHK2
HBHK3
HBHK4
HBHK5
HBHK6
HBHK7
HBHK8
HHRG = C1F3S2/Clinical = Low, Functional = High, Service = Mod
HBHL1
HBHL2
HBHL3
HBHL4
HBHL5
HBHL6
HBHL7
HBHL8
HHRG = C1F3S3/Clinical = Low, Functional = High, Service = High

HBHM1
HBHM2
HBHM3
HBHM4
HBHM5
HBHM6
HBHM7
HBHM8
HHRG = C1F4S0/Clinical = Low, Functional = Max, Service = Min
HBIJ1
HBIJ2
HBIJ3
HBIJ4
HBIJ5
HBIJ6
HBIJ7
HBIJ8
HHRG = C1F4S1/Clinical = Low, Functional = Max, Service = Low
HBIK1
HBIK2
HBIK3
HBIK4
HBIK5
HBIK6
HBIK7
HBIK8
HHRG = C1F4S2/Clinical = Low, Functional = Max, Service = Mod
HBIL1
HBIL2
HBIL3
HBIL4
HBIL5
HBIL6
HBIL7
HBIL8
HHRG = C1F4S3/Clinical = Low, Functional = Max, Service = High

1 CLM_HIPPS_TB Claim SNF & HHA Health Insurance PPS Table

HBIM1
HBIM2
HBIM3
HBIM4
HBIM5
HBIM6
HBIM7
HBIM8
HHRG = C2F0S0/Clinical = Mod, Functional = Min, Service = Min
HCEJ1
HCEJ2
HCEJ3
HCEJ4
HCEJ5
HCEJ6
HCEJ7
HCEJ8
HHRG = C2F0S1/Clinical = Mod, Functional = Min, Service = Low
HCEK1

HCEK2
HCEK3
HCEK4
HCEK5
HCEK6
HCEK7
HCEK8
HHRG = C2F0S2/Clinical = Mod, Functional = Min, Service = Mod
HCEL1
HCEL2
HCEL3
HCEL4
HCEL5
HCEL6
HCEL7
HCEL8
HHRG = C2F0S3/Clinical = Mod, Functional = Min, Service = High
HCEM1
HCEM2
HCEM3
HCEM4
HCEM5
HCEM6
HCEM7
HCEM8
HHRG = C2F1S0/Clinical = Mod, Functional = Low, Service = Min
HCFJ1
HCFJ2
HCFJ3
HCFJ4
HCFJ5
HCFJ6
HCFJ7
HCFJ8
HHRG = C2F1S2/Clinical = Mod, Functional = Low, Service = Mod
HCFL1
HCFL2
HCFL3
HCFL4

HCFL5
HCFL6
HCFL7
HCFL8
HHRG = C2F1S3/Clinical = Mod, Functional = Low, Service = High
HCFM1
HCFM2
HCFM3
HCFM4
HCFM5
HCFM6
HCFM7
HCFM8
HHRG = C2F2S0/Clinical = Mod, Functional = Mod, Service = Min
HCGJ1
HCGJ2

HCGJ3
HCGJ4
HCGJ5
HCGJ6
HCGJ7
HCGJ8
HHRG = C2F2S1/Clinical = Mod, Functional = Mod, Service = Low
HCGK1
HCGK2
HCGK3
HCGK4
HCGK5
HCGK6
HCGK7
HCGK8
HHRG = C2F2S2/Clinical = Mod, Functional = Mod, Service = Mod
HCGL1
HCGL2
HCGL3
HCGL4
HCGL5
HCGL6
HCGL7
HCGL8
HHRG = C2F2S3/Clinical = Mod, Functional = Mod, Service = High
HCGM1
HCGM2
HCGM3
HCGM4
HCGM5
HCGM6
HCGM7
HCGM8
HHRG = C2F3S0/Clinical = Mod, Functional = High, Service = Min
HCHJ1
HCHJ2
HCHJ3
HCHJ4
HCHJ5
HCHJ6
HCHJ7
HCHJ8

1 CLM_HIPPS_TB Claim SNF & HHA Health Insurance PPS Table

HHRG = C2F3S1/Clinical = Mod, Functional = High, Service = Low
HCHK1
HCHK2
HCHK3
HCHK4
HCHK5
HCHK6
HCHK7
HCHK8
HHRG = C2F3S2/Clinical = Mod, Functional = High, Service = Mod
HCHL1
HCHL2
HCHL3

HCHL4
HCHL5
HCHL6
HCHL7
HCHL8
HHRG = C2F3S3/Clinical = Mod, Functional = High, Service = High
HCHM1
HCHM2
HCHM3
HCHM4
HCHM5
HCHM6
HCHM7
HCHM8
HHRG = C2F4S0/Clinical = Mod, Functional = Max, Service = Min
HCIJ1
HCIJ2
HCIJ3
HCIJ4
HCIJ5
HCIJ6
HCIJ7
HCIJ8
HHRG = C2F4S1/Clinical = Mod, Functional = Max, Service = Low
HCIK1
HCIK2
HCIK3
HCIK4
HCIK5
HCIK6
HCIK7
HCIK8
HHRG = C2F4S2/Clinical = Mod, Functional = Max, Service = Mod
HCIL1
HCIL2
HCIL3
HCIL4
HCIL5
HCIL6
HCIL7
HCIL8
HHRG = C2F4S3/Clinical = Mod, Functional = Max, Service = High
HCIM1
HCIM2
HCIM3

1 CLM_HIPPS_TB Claim SNF & HHA Health Insurance PPS Table

HCIM4
HCIM5
HCIM6
HCIM7
HCIM8
HHRG = C3F0S0/Clinical = High, Functional = Min, Service = Min
HDEJ1
HDEJ2
HDEJ3
HDEJ4

HDEJ5
HDEJ6
HDEJ7
HDEJ8
HHRG = C3F0S1/Clinical = High, Functional = Min, Service = Low
HDEK1
HDEK2
HDEK3
HDEK4
HDEK5
HDEK6
HDEK7
HDEK8
HHRG = C3F0S2/Clinical = High, Functional = Min, Service = Mod
HDEL1
HDEL2
HDEL3
HDEL4
HDEL5
HDEL6
HDEL7
HDEL8
HHRG = C3F0S3/Clinical = High, Functional = Min, Service = High
HDEM1
HDEM2
HDEM3
HDEM4
HDEM5
HDEM6
HDEM7
HDEM8
HHRG = C3F1S0/Clinical = High, Functional = Low, Service = Min
HDFJ1
HDFJ2
HDFJ3
HDFJ4
HDFJ5
HDFJ6
HDFJ7
HDFJ8
HHRG = C3F1S1/Clinical = High, Functional = Low, Service = Low
HDFK1
HDFK2
HDFK3
HDFK4
HDFK5
HDFK6
HDFK7

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table
	---	---	---

HDFK8
HHRG = C3F1S2/Clinical = High, Functional = Low, Service = Mod
HDFL1
HDFL2
HDFL3
HDFL4
HDFL5

HDFL6
HDFL7
HDFL8
HHRG = C3F1S3/Clinical = High, Functional = Low, Service = High
HDFM1
HDFM2
HDFM3
HDFM4
HDFM5
HDFM6
HDFM7
HDFM8
HHRG = C3F2S0/Clinical = High, Functional = Mod, Service = Min
HDGJ1
HDGJ2
HDGJ3
HDGJ4
HDGJ5
HDGJ6
HDGJ7
HDGJ8
HHRG = C3F2S1/Clinical = High, Functional = Mod, Service = Low
HDGK1
HDGK2
HDGK3
HDGK4
HDGK5
HDGK6
HDGK7
HDGK8
HHRG = C3F2S2/Clinical = High, Functional = Mod, Service = Mod
HDGL1
HDGL2
HDGL3
HDGL4
HDGL5
HDGL6
HDGL7
HDGL8
HHRG = C3F2S3/Clinical = High, Functional = Mod, Service = High
HDGM1
HDGM2
HDGM3
HDGM4
HDGM5
HDGM6
HDGM7
HDGM8
HHRG = C3F3S0/Clinical = High, Functional = High, Service = Min
HDHJ1
HDHJ2

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table

HDHJ3
HDHJ4
HDHJ5
HDHJ6

HDHJ7
HDHJ8
HHRG = C3F3S1/Clinical = High, Functional = High, Service = Low
HDHK1
HDHK2
HDHK3
HDHK4
HDHK5
HDHK6
HDHK7
HDHK8
HHRG = C3F3S2/Clinical = High, Functional = High, Service = Mod
HDHL1
HDHL2
HDHL3
HDHL4
HDHL5
HDHL6
HDHL7
HDHL8
HHRG = C3F3S3/Clinical = High, Functional = High, Service = High
HDHM1
HDHM2
HDHM3
HDHM4
HDHM5
HDHM6
HDHM7
HDHM8
HHRG = C3F4S0/Clinical = High, Functional = Max, Service = Min
HDIJ1
HDIJ2
HDIJ3
HDIJ4
HDIJ5
HDIJ6
HDIJ7
HDIJ8
HHRG = C3F4S1/Clinical = High, Functional = Max, Service = Low
HDIK1
HDIK2
HDIK3
HDIK4
HDIK5
HDIK6
HDIK7
HDIK8
HHRG = C3F4S2/Clinical = High, Functional = Max, Service = Mod
HDIL1
HDIL2
HDIL3
HDIL4
HDIL5
HDIL6

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance PPS Table
	---	---

HDIL7

HDIL8
HHRG = C3F4S3/Clinical = High, Functional = Max, Service = High
HDIM1
HDIM2
HDIM3
HDIM4
HDIM5
HDIM6
HDIM7
HDIM8

1 CLM_IP_ADMSN_TYPE_TB — Claim Inpatient Admission Type Table

0 = Blank
1 = Emergency - The patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2 = Urgent - The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.
3 = Elective - The patient's condition permitted adequate time to schedule the availability of suitable accommodations.
4 = Newborn - Necessitates the use of special source of admission codes.

5 THRU 8 = Reserved.
9 = Unknown - Information not available.

1 CLM_MDCR_NPMT_RSN_TB — Claim Medicare Non-Payment Reason Table

A = Covered worker's compensation (Obsolete)
B = Benefit exhausted
C = Custodial care - noncovered care (includes all 'beneficiary at fault' waiver cases) (Obsolete)
E = HMO out-of-plan services not emergency or urgently needed (Obsolete)
E = MSP cost avoided - IRS/SSA/HCFA Data Match (eff. 7/00)
F = MSP cost avoid HMO Rate Cell (eff. 7/00)
G = MSP cost avoided Litigation Settlement (eff. 7/00)
H = MSP cost avoided Employer Voluntary Reporting (eff. 7/00)
J = MSP cost avoid Insurer Voluntary Reporting (eff. 7/00)
K = MSP cost avoid Initial Enrollment

Questionnaire (eff. 7/00)
N = All other reasons for nonpayment
P = Payment requested
Q = MSP cost avoided Voluntary Agreement (eff. 7/00)
R = Benefits refused, or evidence not submitted
T = MSP cost avoided - IEQ contractor (eff. 9/76) (obsolete 6/30/00)
U = MSP cost avoided - HMO rate cell adjustment (eff. 9/76) (Obsolete 6/30/00)
V = MSP cost avoided - litigation settlement (eff. 9/76) (Obsolete 6/30/00)
W = Worker's compensation (Obsolete)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data match project (obsolete 6/30/00)
Z = Zero reimbursement RAPs -- zero reimbursement made due to medical review intervention or where provider specific zero payment has been determined. (effective with HHPPS - 10/00)

1 CLM_OCRNC_SPAN_TB — Claim Occurrence Span Table

70 = Eff 10/93, payer use only, the nonutilization from/thru dates for PPS-inlier stay where bene had exhausted all full/coinsurance days, but covered on cost report.
SNF qualifying hospital stay from/thru dates
71 = Hospital prior stay dates - the from/thru dates of any hospital stay that ended within 60 days of this hospital or SNF admission.
72 = First/last visit - the dates of the first and last visits occurring in this billing period if the dates are different from those in the statement covers period.
73 = Benefit eligibility period - the inclusive dates during which CHAMPUS medical benefits are available to a sponsor's bene as shown on the bene's ID card.
74 = Non-covered level of care - The from/thru dates of a period at a noncovered level of care in an otherwise covered stay, excluding any period reported with occurrence span code 76, 77, or 79.
75 = The from/thru dates of SNF level of care during IP hospital stay. Shows PRO approval of patient remaining in hospital because SNF bed not available. not applicable to swing bed cases. PPS hospitals use in day outlier cases only.

76 = Patient liability - From/thru
dates of period of noncovered care
for which hospital may charge
bene. The FI or PRO must have
approved such charges in advance.
patient must be notified in writing
3 days prior to noncovered period
77 = Provider liability - The from/thru
dates of period of noncovered care
for which the provider is liable.
Eff 3/92, applies to provider liability
where bene is charged with utilization
and is liable for deductible/coinsurance
78 = SNF prior stay dates - The from/
thru dates of any SNF stay that
ended within 60 days of this hospital
or SNF admission.
79 = (Payer code) -
Eff 3/92, from/thru dates of
period of noncovered care where
bene is not charged with utilization,
deductible, or coinsurance.
and provider is liable.
Eff 9/93, noncovered period of care
due to lack of medical necessity.

1 CLM_OCRNC_SPAN_TB — Claim Occurrence Span Table

80 - 99 = Reserved for state assignment
M0 = PRO/UR approved stay dates - Eff 10/93,
the first and last days that were
approved where not all of the stay was
approved.

1 CLM_PPS_IND_TB — Claim PPS Indicator Table

Effective NCH weekly process date 10/3/97 - 5/29/98

0 = not PPS bill (claim contains no PPS indicator)
2 = PPS bill (claim contains PPS indicator)

Effective NCH weekly process date 6/5/98

0 = not applicable (claim contains neither PPS
nor deemed insured MQGE status indicators)
1 = Deemed insured MQGE (claim contains deemed
insured MQGE indicator but not PPS indicator)
2 = PPS bill (claim contains PPS indicator but no
deemed insured MQGE status indicator)
3 = Both PPS and deemed insured MQGE (contains both
PPS and deemed insured MQGE indicators)

1 CLM_RLT_COND_TB — Claim Related Condition Table

01 = Military service related - Medical condition incurred during military service.
02 = Employment related - Patient alleged that the medical condition causing this episode of care was due to environment/ events resulting from employment.
03 = Patient covered by insurance not reflected here - Indicates that patient or patient representative has stated that coverage may exist beyond that reflected on this bill.
04 = Health Maintenance Organization (HMO) enrollee - Medicare beneficiary is enrolled in an HMO. Eff 9/93, hospital must also expect to receive payment from HMO.
05 = Lien has been filed - Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.
06 = ESRD patient in 1st 18 months of entitlement covered by employer group health insurance - indicates Medicare may be secondary insurer. Eff 3/1/96, ESRD patient in 1st 30 months of entitlement covered by employer group health insurance.
07 = Treatment of nonterminal condition for hospice patient - The patient is a hospice enrollee, but the provider is not treating a terminal condition and is requesting Medicare reimbursement.
08 = Beneficiary would not provide information concerning other insurance coverage.
09 = Neither patient nor spouse is employed - Code indicates that in response to development questions, the patient and spouse have denied employment.
10 = Patient and/or spouse is employed but no EGHP coverage exists or (eff 9/93) other employer sponsored/provided health insurance covering patient.
11 = The disabled beneficiary and/or family member has no group coverage from a LGHP or (eff 9/93) other employer sponsored/provided health insurance covering patient.
12 = Payer code - Reserved for internal use only by third party payers. HCFA will assign as needed. Providers will not report them.
13 = Payer code - Reserved for internal use only by third party payers. HCFA will assign as needed. Providers will not report them.
14 = Payer code - Reserved for internal

1 CLM_RLT_COND_TB Claim Related Condition Table

use only by third party payers. HCFA will assign as needed. Providers will not report them.

15 = Clean claim (eff 10/92)

16 = SNF transition exemption - An exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date

17 = Patient is over 100 years old - Code indicates that the patient was over 100 years old at the date of admission.

18 = Maiden name retained - A dependent spouse entitled to benefits who does not use her husband's last name.

19 = Child retains mother's name - A patient who is a dependent child entitled to CHAMPVA benefits that does not have father's last name.

20 = Bene requested billing - Provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the bene has requested formal determination

21 = Billing for denial notice - The SNF or HHA realizes services are at a noncovered level of care or excluded, but requests a Medicare denial in order to bill medicaid or other insurer

22 = Patient on multiple drug regimen - A patient who is receiving multiple intravenous drugs while on home IV therapy

23 = Homecaregiver available - The patient has a caregiver available to assist him or her during self-administration of an intravenous drug

24 = Home IV patient also receiving HHA services - the patient is under care of HHA while receiving home IV drug therapy services

25 = Reserved for national assignment

26 = VA eligible patient chooses to receive services in Medicare certified facility rather than a VA facility (eff 3/92)

27 = Patient referred to a sole community hospital for a diagnostic laboratory test - (sole community hospital only). (eff 9/93)

28 = Patient and/or spouse's EGHP is secondary to Medicare - Qualifying EGHP for employers who have fewer than 20 employees. (eff 9/93)

29 = Disabled beneficiary and/or family member's LGHP is secondary to Medicare - Qualifying LGHP for

employer having fewer than 100 full and part-time employees

1 CLM_RLT_COND_TB — Claim Related Condition Table

31 = Patient is student (full time - day) - Patient declares that he or she is enrolled as a full time day student.
32 = Patient is student (cooperative/work study program)
33 = Patient is student (full time - night) - Patient declares that he or she is enrolled as a full time night student.
34 = Patient is student (part time) - Patient declares that he or she is enrolled as a part time student.
36 = General care patient in a special unit - Patient is temporarily placed in special care unit bed because no general care beds were available.
37 = Ward accommodation is patient's request - Patient is assigned to ward accommodations at patient's request.
38 = Semi-private room not available - Indicates that either private or ward accommodations were assigned because semi-private accomodations were not available.
39 = Private room medically necessary - Patient needed a private room for medical reasons.
40 = Same day transfer - Patient transferred to another facility before midnight of the day of admission.
41 = Partial hospitalization - Eff 3/92, indicates claim is for partial hospitalization services. For OP services, this includes a variety of psych programs.
42 = Reserved for national assignment.
43 = Reserved for national assignment.
44 = Reserved for national assignment.
45 = Reserved for national assignment.
46 = Nonavailability statement on file for CHAMPUS claim for nonemergency IP care for CHAMPUS bene residing within the catchment area (usually a 40 mile radius) of a uniform services hospital.
47 = Reserved for CHAMPUS.
48 = Reserved for national assignment.
49 = Reserved for national assignment.
50 = Reserved for national assignment.
51 = Reserved for national assignment.
52 = Reserved for national assignment.
53 = Reserved for national assignment.
54 = Reserved for national assignment.
55 = SNF bed not available - The patient's SNF admission was delayed more than 30

days after hospital discharge because a SNF bed was not available.
56 = Medical appropriateness - Patient's SNF admission was delayed more than 30 days after hospital discharge because physical condition made it inappropriate to begin active care within that period
57 = SNF readmission - Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58 = Payment of SNF claims for beneficiaries disenrolling from terminating M+C plans plans who have not met the 3-day hospital stay requirement (eff. 10/1/00)
59 = Reserved for national assignment.
60 = Operating cost day outlier - PRICER indicates this bill is length of stay outlier (PPS)
61 = Operating cost cost outlier - PRICER indicates this bill is a cost outlier (PPS)
62 = PIP bill - This bill is a periodic interim payment bill.
63 = PRO denial received before batch clearance report - The HCSSACL receipt date is used on PRO adjustment if the PRO's notification is before orig bill's acceptance report. (Payer only code eff 9/93)
64 = Other than clean claim - The claim is not a 'clean claim'
65 = Non-PPS code - The bill is not a prospective payment system bill.
66 = Outlier not claimed - Bill may meet the criteria for cost outlier, but the hospital did not claim the cost outlier (PPS)
67 = Beneficiary elects not to use LTR days
68 = Beneficiary elects to use LTR days
69 = Operating IME Payment Only - providers request for IME payment for each discharge of MCO enrollee, beginning 1/1/98, from teaching hospitals (facilities with approved medical residency training program); not stored in NCH. Exception: problem in startup year may have resulted in this special IME payment request being erroneously stored in NCH. If present, disregard claim as condition code '69' is not valid NCH claim.
70 = Self-administered EPO - Billing is for a home dialysis patient who self administers EPO.
71 = Full care in unit - Billing is for a patient who received staff assisted

dialysis services in a hospital or
renal dialysis facility.
72 = Self care in unit - Billing is for a
patient who managed his own dialysis
services without staff assistance in a
hospital or renal dialysis facility.
73 = Self care training - Billing is for
special dialysis services where the

1 CLM_RLT_COND_TB Claim Related Condition Table
--- ---------- ---------- ----------

patient and helper (if necessary) were
learning to perform dialysis.
74 = Home - Billing is for a patient who
received dialysis services at home.
75 = Home 100% reimbursement -
(not to be used for services after 4/15/90)
The billing is for home dialsis patient using
a dialysis machine that was purchased
under the 100% program.
76 = Back-up facility - Billing is for a
patient who received dialysis services
in a back-up facility.
77 = Provider accepts or is obligated/
required due to contractual agreement
or law to accept payment by a primary
payer as payment in full - Medicare
pays nothing.
78 = New coverage not implemented by HMO -
eff 3/92, indicates newly covered
service under Medicare for which HMO
does not pay.
79 = CORF services provided off site -
Code indicates that physical therapy,
occupational therapy, or speech path-
ology services were provided off site.
80 - 99 = Reserved for state assignment.
A0 = CHAMPUS external partnership program
special program indicator code. (eff 10/93)
A1 = EPSDT/CHAP - Early and periodic
screening diagnosis and treatment
special program indicator code. (eff 10/93)
A2 = Physically handicapped children's
program - Services provided receive
special funding through Title 8 of
the Social Security Act or the CHAMPUS
program for the handicapped. (eff 10/93)
A3 = Special federal funding - Designed for
uniform use by state uniform billing
committees.
Special program indicator code (eff 10/93)
A4 = Family planning - Designed for
uniform use by state uniform billing
committees.
Special program indicator code (eff 10/93)
A5 = Disability - Designed for uniform
use by state uniform billing
committees.

Special program indicator code (eff 10/93)
A6 = PPV/Medicare - Identifies that pneumococcal pneumonia 100% payment vaccine (PPV) services should be reimbursed under a special Medicare program provision.
Special program indicator code (eff 10/93)
A7 = Induced abortion to avoid danger to woman's life.
Special program indicator code (eff 10/93)
A8 = Induced abortion - Victim of rape/ incest.
Special program indicator code (eff 10/93)
A9 = Second opinion surgery - Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.
Special program indicator code (eff 10/93)
B0 = Special program indicator Reserved for national assignment.
B1 = Special program indicator Reserved for national assignment.
B2 = Special program indicator Reserved for national assignment.
B3 = Special program indicator Reserved for national assignment.
B4 = Special program indicator Reserved for national assignment.
B5 = Special program indicator Reserved for national assignment.
B6 = Special program indicator Reserved for national assignment.
B7 = Special program indicator Reserved for national assignment.
B8 = Special program indicator Reserved for national assignment.
B9 = Special program indicator Reserved for national assignment.
C0 = Reserved for national assignment.
C1 = Approved as billed - The services provided for this billing period have been reviewed by the PRO/UR or intermediary and are fully approved including any day or cost outlier. (eff 10/93)
C2 = Automatic approval as billed based on focused review. (No longer used for Medicare)
PRO approval indicator services (eff 10/93)
C3 = Partial approval - The services provided for this billing period have been reviewed by the PRO/UR or intermediary and some portion has been denied (days or services). (eff 10/93)
C4 = Admission/services denied - Indicates that all of the services were denied

by the PRO/UR.
PRO approval indicator services (eff 10/93)
C5 = Postpayment review applicable - PRO/UR review to take place after payment.
PRO approval indicator services (eff 10/93)
C6 = Admission preauthorization - The PRO/UR authorized this admission/ service but has not reviewed the services provided.
PRO approval indicator services (eff 10/93)
C7 = Extended authorization - the PRO has authorized these services for an extended length of time but has not reviewed the services provided.

1 CLM_RLT_COND_TB — Claim Related Condition Table

PRO approval indicator services (eff 10/93)
C8 = Reserved for national assignment.
PRO approval indicator services (eff 10/93)
C9 = Reserved for national assignment.
PRO approval indicator services (eff 10/93)
D0 = Changes to service dates.
Change condition (eff 10/93)
D1 = Changes in charges.
Change condition (eff 10/93)
D2 = Changes in revenue codes/HCPCS.
Change condition (eff 10/93)
D3 = Second or subsequent interim PPS bill.
Change condition (eff 10/93)
D4 = Change in grouper input (diagnosis and/or procedures are changed resulting in a different DRG).
Change condition (eff 10/93)
D5 = Cancel only to correct a beneficiary claim account number or provider identification number.
change condition (eff 10/93)
D6 = Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an OP bill containing services required to be included on the IP bill). Change condition eff 10/93.
D7 = Change to make Medicare the secondary payer.
Change condition (eff 10/93)
D8 = Change to make Medicare the primary payer.
Change condition (eff 10/93)
D9 = Any other change.
Change condition (eff 10/93)
E0 = Change in patient status.
Change condition (eff 10/93)
EY = National Emphysema Treatment Trial (NETT) or Lung Volume Reduction Surgery (LVRS) clinical study (eff. 11/97)
G0 = Multiple medical visits occur on the same

day in the same revenue center but visits are distinct and constitute independent visits (allows for payment under outpatient PPS -- eff. 7/3/00).
M0 = All inclusive rate for outpatient services. (payer only code)
M1 = Roster billed influenza virus vaccine. (payer only code) Eff 10/96, also includes pneumoccocal pneumonia vaccine (PPV)
M2 = HH override code - home health total reimbursement exceeds the $150,000 cap or the number of total visits exceeds the 150 limitation. (eff 4/3/95) (payer only code)
W0 = United Mine Workers of America (UMWA) SNF demonstration indicator (eff 1/97);

1 CLM_RLT_COND_TB — Claim Related Condition Table

but no claims transmitted until 2/98)

1 CLM_RLT_OCRNC_TB — Claim Related Occurrence Table

01 = Auto accident - The date of an auto accident.
02 = No-fault insurance involved, including auto accident/other - The date of an accident where the state has applicable no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).
03 = Accident/tort liability - The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04 = Accident/employment related - The date of an accident relating to the patient's employment.
05 = Other accident - The date of an accident not described by the codes 01 thru 04.
06 = Crime victim - Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07 = Reserved for national assignment.
08 = Reserved for national assignment.
11 = Onset of symptoms/illness - The date the patient first became aware of symptoms/illness.
12 = Date of onset for a chronically dependent individual - Code indicates the date the patient/bene became a chronically dependent individual.

13 = Reserved for national assignment.
14 = Reserved for national assignment.
15 = Reserved for national assignment.
16 = Reserved for national assignment.
17 = Date outpatient occupational therapy plan established or last reviewed - Code indicating the date an occupational therapy plan was established or last reviewed (eff 3/93)
18 = Date of retirement (patient/bene) - Code indicates the date of retirement for the patient/bene.
19 = Date of retirement spouse - Code indicates the date of retirement for the patient's spouse.
20 = Guarantee of payment began - The date on which the provider began claiming Medicare payment under the guarantee of payment provision.
21 = UR notice received - Code indicating the date of receipt by the hospital of the UR committee's finding that the admission or future stay was not medically necessary.
22 = Active care ended - The date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis hospital. (For use by intermediary only)
23 = Reserved for national assignment (eff 10/93).
Benefits exhausted - The last date for which benefits can be paid. (term 9/30/93; replaced by code A3)
24 = Date insurance denied - The date the insurer's denial of coverage was received by a higher priority payer.
25 = Date benefits terminated by primary payer - The date on which coverage (including worker's compensation benefits or no-fault coverage) is no longer available to the patient.
26 = Date skilled nursing facility (SNF) bed available - The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
27 = Date home health plan established or last reviewed - Code indicating the date a home health plan of treatment was established or last reviewed. not used by hospital unless owner of facility
28 = Date comprehensive outpatient rehabilitation plan established or last reviewed - Code indicating the date a

comprehensive outpatient rehabilitation plan was established or last reviewed. not used by hospital unless owner of facility

29 = Date OPT plan established or last reviewed - the date a plan of treatment was established for outpatient physical therapy. Not used by hospital unless owner of facility

30 = Date speech pathology plan treatment established or last reviewed - The date a speech pathology plan of treatment was established or last reviewed. Not used by hospital unless owner of facility

31 = Date bene notified of intent to bill (accommodations) - The date of the notice provided to the patient by the hospital stating that he no longer required a covered level of IP care.

32 = Date bene notified of intent to bill (procedures or treatment) - The date of the notice provided to the patient by the hospital stating requested care (diagnostic procedures or treatments) is not considered reasonable or necessary.

33 = First day of the Medicare coordination period for ESRD bene - During which Medicare benefits are secondary to benefits payable under an EGHP. Required only for ESRD beneficiaries.

34 = Date of election of extended care facilities - The date the guest elected to receive extended care services (used by Christian Science Sanatoria only).

35 = Date treatment started for physical therapy - Code indicates the date services were initiated by the billing provider for physical therapy.

36 = Date of discharge for the IP hospital stay when patient received a transplant procedure - Hospital is billing for immunosuppressive drugs.

37 = The date of discharge for the IP hospital stay when patient received a noncovered transplant procedure - Hospital is billing for immunosuppresive drugs.

38 = Date treatment started for home IV therapy - Date the patient was first treated in his home for IV therapy.

39 = Date discharged on a continuous course of IV therapy - Date the patient was discharged from the hospital on a continuous course of IV therapy.

40 = Scheduled date of admission - The

1	CLM_RLT_OCRNC_TB	Claim Related Occurrence Table

date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)

41 = The date on which the first outpatient diagnostic test was performed as part of a pre-admission testing (PAT) program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s).

42 = Date of discharge/termination of hospice care - for the final bill for hospice care. Eff 5/93, definition revised to apply only to date patient revoked hospice election.

43 = Reserved for national assignment.

44 = Date treatment started for occupational therapy - Code indicates the date services were initiated by the billing provider for occupational therapy.

45 = Date treatment started for speech therapy - Code indicates the date services were initiated by the billing provider for speech therapy.

46 = Date treatment started for cardiac rehabilitation - Code indicates the date services were initiated by the billing provider for cardiac rehabilitation.

47 = Noncovered Outlier Stay Began- code

indicates the date that cost outlier status began and no Medicare payment will be made because all benefits have been exhausted during the inlier stay or the beneficiary does not elect to use life time reserve days (to be implemented in 1999).

48 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.

49 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.

50 - 69 = Reserved for state assignment

A1 = Birthdate, Insured A - The birthdate of the individual in whose name the insurance is carried. (Eff 10/93)

A2 = Effective date, Insured A policy - A code indicating the first date insurance is in force. (eff 10/93)

A3 = Benefits exhausted - Code indicating the last date for which benefits are

available and after which no payment
can be made to payer A. (eff 10/93)
B1 = Birthdate, Insured B - The birthdate of
the individual in whose name the insurance
is carried. (eff 10/93)
B2 = Effective date, Insured B policy - A
code indicating the first date insurance
is in force. (eff 10/93)
B3 = Benefits exhausted - code indicating
the last date for which benefits are
available and after which no payment
can be made to payer B. (eff 10/93)
C1 = Birthdate, Insured C - The birthdate of
the individual in whose name the insurance
is carried. (eff 10/93)
C2 = Effective date, Insured C policy - A
code indicating the first date insurance
is in force. (eff 10/93)
C3 = Benefits exhausted - Code indicating
the last date for which benefits are
available and after which no payment
can be made to payer C. (eff 10/93)

1 CLM_SRC_IP_ADMSN_TB Claim Source Of Inpatient Admission Table

For Inpatient/SNF Claims:

0 = ANOMALY: invalid value, if present,
translate to '9'
1 = Physician referral - The patient was
admitted upon the recommendation of
a personal physician.
2 = Clinic referral - The patient was
admitted upon the recommendation of
this facility's clinic physician.
3 = HMO referral - The patient was admitted
upon the recommendation of an health
maintenance organization (HMO)
physician.
4 = Transfer from hospital - The patient
was admitted as an inpatient transfer
from an acute care facility.
5 = Transfer from a skilled nursing
facility (SNF) - The patient was
admitted as an inpatient transfer
from a SNF.
6 = Transfer from another health care
facility - The patient was admitted
as a transfer from a health care
facility other than an acute care
facility or SNF.
7 = Emergency room - The patient was
admitted upon the recommendation of
this facility's emergency room
physician.

8 = Court/law enforcement - The patient was
admitted upon the direction of a
court of law or upon the request of
a law enforcement agency's
representative.
9 = Information not available - The means
by which the patient was admitted is
not known.
A = Transfer from a Critical Access Hospital -
patient was admitted/referred to this
facility as a transfer from a Critical
Access Hospital.

For Newborn Type of Admission

1 = Normal delivery - A baby delivered with
out complications.
2 = Premature delivery - A baby delivered
with time and/or weight factors
qualifying it for premature status.
3 = Sick baby - A baby delivered with
medical complications, other than those
relating to premature status.
4 = Extramural birth - A baby delivered in
a nonsterile environment.
5-8 = Reserved for national assignment.
9 = Information not available.

1 CLM_SRC_IP_ADMSN_TB — Claim Source Of Inpatient Admission Table

1 CLM_SRVC_CLSFCTN_TYPE_TB — Claim Service Classification Type Table

For facility type code 1 thru 6, and 9

1 = Inpatient (including Part A)
2 = Hospital based or Inpatient (Part B only)
or home health visits under Part B
3 = Outpatient (HHA-A also)
4 = Other (Part B)
5 = Intermediate care - level I
6 = Intermediate care - level II
7 = Subacute Inpatient
(formerly Intermediate care - level III)
8 = Swing beds (used to indicate billing for
SNF level of care in a hospital with an
approved swing bed agreement)
9 = Reserved for national assignment

For facility type code 7

1 = Rural health
2 = Hospital based or independent renal
dialysis facility
3 = Free-standing provider based federally
qualified health center (eff 10/91)

4 = Other Rehabilitation Facility (ORF) and
Community Mental Health Center (CMHC)
(eff 10/91 - 3/97); ORF only (eff. 4/97)
5 = Comprehensive Rehabilitation Center
(CORF)
6 = Community Mental Health Center (CMHC) (eff 4/97)
7-8 = Reserved for national assignment
9 = Other

For facility type code 8

1 = Hospice (non-hospital based)
2 = Hospice (hospital based)
3 = Ambulatory surgical center in hospital
outpatient department
4 = Freestanding birthing center
5 = Critical Access Hospital (eff. 10/99)
formerly Rural primary care hospital
(eff. 10/94)
6-8 = Reserved for national use
9 = Other

1 CLM_TRANS_TB — Claim Transaction Table

0 = Religious NonMedical Health Care Institutions (RNHCI)
bill (prior to 8/00, Christian Science bill), SNF bill,
or state buy-in
1 = Psychiatric hospital facility bill or dummy psychiatric
2 = Tuberculosis hospital facility bill
3 = General care hospital facility bill or dummy LRD
4 = Regular SNF bill
5 = Home health agency bill (HHA)
6 = Outpatient hospital bill
C = CORF bill - type of OP bill in the HHA bill format
(obsoleted 7/98)
H = Hospice bill

1 CLM_VAL_TB — Claim Value Table

04 = Inpatient professional component
charges which are combined billed -
For use only by some all inclusive
rate hospitals. (Eff 9/93)
05 = Professional component included in
charges and also billed separately to
carrier - For use on Medicare and
Medicaid bills if the state requests
this information.
06 = Medicare blood deductible - Total
cash blood deductible (Part A blood
deductible).
07 = Medicare cash deductible (term 9/30/93)
reserved for national assignment.
(eff 10/93)

08 = Medicare Part A lifetime reserve amount
in first calendar year - Lifetime reserve
amount charged in the year of admission.
(not stored in NCH until 2/93)
09 = Medicare Part A coinsurance amount in
the first calendar year - Coinsurance
amount charged in the year of admission.
(not stored in NCH until 2/93)
10 = Medicare Part A lifetime reserve amount
in the second calendar year - Lifetime
reserve amount charged in the year of
discharge where the bill spans two
calendar years.
(not stored in NCH until 2/93)
11 = Medicare Part A coinsurance amount in
the second calendar year - Coinsurance
amount charged in the year of discharge
where the bill spans two calendar years
(not stored in NCH until 2/93)
12 = Amount is that portion of
higher priority EGHP insurance payment
made on behalf of aged bene
provider applied to Medicare
covered services on this bill.
Six zeroes indicate provider
claimed conditional Medicare payment.
13 = Amount is that portion of higher
priority EGHP insurance payment made on
behalf of ESRD bene provider
applied to Medicare covered services
on this bill. Six zeroes indicate
the provider claimed conditional
Medicare payment.
14 = That portion of payment from higher
priority no fault auto/other
liability insurance made on behalf of bene
provider applied to Medicare covered
services on this bill. Six zeroes indicate
provider claimed conditional payment
15 = That portion of a payment from a
higher priority WC plan made on behalf
of a bene that the provider applied to

1 CLM_VAL_TB Claim Value Table
---------- -----------------

Medicare covered services on this bill. Six
zeroes indicate the provider claimed
conditional Medicare payment.
16 = That portion of a payment from
higher priority PHS or other federal
agency made on behalf of a
bene the provider applied
to Medicare covered services on this
bill. Six zeroes indicate
provider claimed conditional Medicare
payment.
17 = Operating Outlier amount - Providers do
not report this. For payer internal use

only. Indicates the amount of day or cost outlier payment to be made. (Do not include any PPS capital outlier payment in this entry).

18 = Operating Disproportionate share amount - Providers do not report this. For payer internal use only. Indicates the disproportionate share amount applicable to the bill. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry).

19 = Operating Indirect medical education amount - Providers do not report this. For payer internal use only. Indicates the indirect medical education amount applicable to the bill. (Do not include PPS capital IME adjustment in this entry).

20 = Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount. (used 10/1/91 - 3/1/92 for provider reporting. Payer only code eff 9/93.)

21 = Catastrophic - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)

22 = Surplus - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)

23 = Recurring monthly income - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)

24 = Medicaid rate code - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)

31 = Patient liability amount - Amount shown is that which you or the PRO approved to charge the bene for noncovered accommodations, diagnostic procedures or treatments.

37 = Pints of blood furnished - Total number of pints of whole blood or units

of packed red cells furnished to the patient. (eff 10/93)

38 = Blood deductible pints - The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. (eff 10/93)

39 = Pints of blood replaced - The total number of pints of whole blood or units of packed red cells furnished to the

patient that have been replaced by or
on behalf of the patient. (eff 10/93)
40 = New coverage not implemented by HMO -
amount shown is for inpatient charges
covered by HMO (eff 3/92).
(use this code when the bill includes
inpatient charges for newly covered
services which are not paid by HMO.)
41 = Amount is that portion of
a payment from higher priority BL
program made on behalf of
bene the provider applied
to Medicare covered services on this
bill. Six zeroes indicate the
provider claimed conditional Medicare
payment.
42 = Amount is that portion of a payment
from higher priority VA made on behalf
of bene the provider applied
to Medicare covered services on this
bill. Six zeroes indicate the
provider claimed conditional Medicare
payment.
43 = Disabled bene under age 65 with
LGHP - Amount is that portion of
a payment from a higher priority LGHP
made on behalf of a disabled Medicare
bene the provider applied to
Medicare covered services on this bill.
44 = Amount provider agreed to accept from
primary payer when amount less than charges
but more than payment received -
When a lesser amount is received and the
received amount is less than charges, a
Medicare secondary payment is due.
46 = Number of grace days - Following the
date of the PRO/UR determination, this
is the number of days determined by the
PRO/UR to be necessary to arrange for
the patient's post-discharge care.
(eff 10/93)
47 = Any liability insurance - Amount
is that portion from a higher priority
liability insurance made on behalf of
Medicare bene the provider
is applying to Medicare covered
services on this bill. (Eff 9/93)
48 = Hemoglobin reading - The latest

hemoglobin reading taken during this
billing cycle.
49 = Latest hematocrit reading taken
during billing cycle - Usually
reported in two pos. (a percentage) to
left of the dollar/cent delimiter.
if provided with a

a decimal, use the 3rd pos. to right of the delimiter for the third digit.

50 = Physical therapy visits - Indicates the number of physical therapy visits from onset (at billing provider) through this billing period.

51 = Occupational therapy visits - Indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period.

52 = Speech therapy visits - Indicates the number of speech therapy visits from onset (at billing provider) through this billing period.

53 = Cardiac rehabilitation - Indicates the number of cardiac rehabilitation visits from onset (at billing provider) through this billing period.

54 = Reserved for national assignment.

55 = Reserved for national assignment.

56 = Hours skilled nursing provided - The number of hours skilled nursing provided during the billing period. Count only hours spent in the home.

57 = Home health visit hours - The number of home health aide services provided during the billing period. Count only the hours spent in the home.

58 = Arterial blood gas - Arterial blood gas value at beginning of each reporting period for oxygen therapy. This value or value 59 will be required on the initial bill for oxygen therapy and on the fourth month's bill.

59 = Oxygen saturation - Oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 will be required on the initial bill for oxygen therapy and on the fourth month's bill.

60 = HHA branch MSA - MSA in which HHA branch is located.

61 = Location of HHA service or hospice service - the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider. (eff. 10/1/97)

62 = Number of Part A home health visits accrued during a period of continuous

care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

63 = Number of Part B home health visits accrued during a period of continuous

care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

64 = Amount of home health payments attributed to the Part A trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

65 = Amount of home health payments attributed to the Part B trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

66 = Reserved for national assignment.

67 = Peritoneal dialysis - The number of hours of peritoneal dialysis provided during the billing period (only the hours spent in the home). (eff. 10/97)

68 = EPO drug - Number of units of EPO administered relating to the billing period.

69 = Reserved for national assignment

70 = Interest amount - (Providers do not report this.) Report the amount applied to this bill.

71 = Funding of ESRD networks - (Providers do not report this.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.

72 = Flat rate surgery charge - Code indicates the amount of the charge for outpatient surgery where the hospital has such a charging structure.

73 = Drug deductible - (For internal use by third party payers only). Report the amount of the drug deductible to be applied to the claim.

74 = Drug coinsurance - (For internal use by third party payers only). Report the amount of drug coinsurance to be applied to the claim.

75 = Gramm/Rudman/Hollings - (Providers do not report this.) Report the amount of the sequestration applied to this bill.

76 = Report provider's percentage of billed charges interim rate during billing period. Applies to OP hospital, SNF and HHA claims where interim rate is applicable. Report to left of dollar/cents delimiter. (TP payers internal use only)

77 = Payer code - This codes is set aside for payer use only. Providers do not report these codes.

1	CLM_VAL_TB	Claim Value Table

78 = Payer code - This codes is set

aside for payer use only. Providers
do not report these codes.
79 = Payer code - This code is set
aside for payer use only. Providers
do not report these codes.
80 - 99 = Reserved for state assignment.
A1 = Deductible Payer A - The amount
assumed by the provider to be applied
to the patient's deductible amount
involving the indicated payer. (eff 10/93)
- Prior value 07
A2 = Coinsurance Payer A - The amount assumed
by the provider to be applied to the
patient's Part B coinsurance amount
involving the indicated payer. (eff 10/93)
A4 = Self-administered drugs administered in an
emergency situation - Ordinarily the only
noncovered self-administered drug
paid for under Medicare in an emergency
situation is insulin administered to a
patient in a diabetic coma. (eff 7/97)
B1 = Deductible Payer B - The amount
assumed by the provider to be applied
to the patient's deductible amount
involving the indicated payer. (eff 10/93)
- Prior value 07
B2 = Coinsurance Payer B - the amount assumed
by the provider to be applied to the
patient's Part B coinsurance amount
involving the indicated payer. (eff 10/93)
C1 = Deductible Payer C - The amount
assumed by the provider to be applied
to the patient's deductible amount
involving the indicated payer. (eff 10/93)
- Prior value 07
C2 = Coinsurance Payer C - The amount assumed
by the provider to be applied to the
patient's Part B coinsurance amount
involving the indicated payer. (eff 10/93)
Y1 = Part A demo payment - Portion of the
payment designated as reimbursement for
Part A services per the ORD contract. No
deductible or coinsurance has been
applied. (eff. 5/97)
Y2 = Part B demo payment - Portion of the
payment designated as reimbursement for
Part B services for the ORD contract.
No deductible or coinsurance has been
applied. (eff. 5/97)
Y3 = Part B coinsurance - Amount of Part B
coinsurance applied by the intermediary
to this demo claim. (eff. 5/97)
Y4 = Conventional provider Part A payment -
Amount Medicare would have reimbursed
the provider for Part A services if
there had been no demo. (eff. 5/97)

1 CTGRY_EQTBL_BENE_IDENT_TB Category Equatable Beneficiary Identification Code (BIC) Table

NCH BIC SSA Categories

A = A;J1;J2;J3;J4;M;M1;T;TA
B = B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;
TB(F);TD(F);TE(F);TW(F)
B1 = B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M)
TD(M);TE(M);TW(M)
B3 = B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2
W7;TG(F);TL(F);TR(F);TX(F)
B4 = B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M)
TL(M);TR(M);TX(M)
B8 = B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4
W8;TH(F);TM(F);TS(F);TY(F)
BA = BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9
WC;TJ(F);TN(F);TT(F);TZ(F)
BD = BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WF
WJ;TK(F);TP(F);TU(F);TV(F)
BG = BG;DH;DQ;DS;EF;EJ;W5;TH(M);TM(M);TS(M)
TY(M)
BH = BH;DJ;DR;DX;EG;EK;WB;TJ(M);TN(M);TT(M)
TZ(M)
BJ = BJ;DK;DT;DZ;EH;EM;WG;TK(M);TP(M);TU(M)
TV(M)
C1 = C1;TC
C2 = C2;T2
C3 = C3;T3
C4 = C4;T4
C5 = C5;T5
C6 = C6;T6
C7 = C7;T7
C8 = C8;T8
C9 = C9;T9
F1 = F1;TF
F2 = F2;TQ
F3-F8 = Equatable only to itself (e.g., F3 IS
equatable to F3)
CA-CZ = Equatable only to itself. (e.g., CA is
only equatable to CA)

RRB Categories

10 = 10
11 = 11
13 = 13;17
14 = 14;16
15 = 15
43 = 43
45 = 45
46 = 46
80 = 80
83 = 83
84 = 84;86
85 = 85

1 DMERC_LINE_SCRN_RSLT_IND_TB — DMERC Line Screen Result Indicator Table

A = Denied for lack of medical necessity; highest level of review was automated level I review
B = Reduced (partially denied) for lack of medical necessity; highest level of review was automated level I review
C = Denied as statutorily noncovered; highest level of review was automated level I review
D = Reserved for future use
E = Paid after automated level I review
F = Denied for lack of medical necessity; highest level of review was manual level I review
G = Reduced (partially denied) for lack of medical necessity; highest level of review was manual level I review
H = Denied as statutorily noncovered; highest level of review was manual level I review
I = Denied for coding/unbundling reasons; highest level of review was manual level I review
J = Paid after manual level I review
K = Denied for lack of medical necessity; highest level of review was manual level II review
L = Reduced (partially denied) for lack of medical necessity; highest level of review was manual level II review
M = Denied as statutorily noncovered; highest level of review was manual level II review
N = Denied for coding/unbundling reasons; highest level of review was manual level II review
O = Paid after manual level II review
P = Denied for lack of medical necessity; highest level of review was manual level III review
Q = Reduced (partially denied) for lack of medical necessity; highest level of review was manual level III review
R = Denied as statutorily noncovered; highest level of review was manual level III review
S = Denied for coding/unbundling reasons; highest level of review was manual level III review
T = Paid after manual level III review

1 DMERC_LINE_SUPLR_TYPE_TB — DMERC Line Supplier Type Table

0 = Clinics, groups, associations, partnerships, or other entities for whom the carrier's own ID number has been assigned.
1 = Physicians or suppliers billing as solo practitioners for whom SSN's are shown in the physician ID code field.
2 = Physicians or suppliers billing as solo practitioners for whom the carrier's own physician ID code is shown.
3 = Suppliers (other than sole proprietorship) for whom EI numbers are used in coding the ID field.
4 = Suppliers (other than sole proprietorship) for whom the carrier's own code has been shown.
5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field.
6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.
7 = Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.
8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

1 DRG_OUTLIER_STAY_TB — Diagnosis Related Group Outlier Patient Stay Table

0 = No outlier
1 = Day outlier (condition code 60)
2 = Cost outlier, (condition code 61)

*** Non-PPS Only ***

6 = Valid diagnosis related groups (DRG) received from the intermediary
7 = HCFA developed DRG
8 = HCFA developed DRG using patient status code
9 = Not groupable

1 FI_CLM_ACTN_TB — Fiscal Intermediary Claim Action Table

1 = Original debit action (includes non-adjustment RTI correction items) - it will always be a 1 in regular bills.
2 = Cancel by credit adjustment - used only in credit/debit pairs (under HHPPS,

updates the RAP).
3 = Secondary debit adjustment - used only in credit/debit pairs (under HHPPS, would be the final claim or an adjustment on a LUPA).
4 = Cancel only adjustment (under HHPPS, RAP/final claim/LUPA).
5 = Force action code 3
6 = Force action code 2
8 = Benefits refused (for inpatient bills, an 'R' nonpayment code must also be present
9 = Payment requested (used on bills that replace previously-submitted benefits-refused bills, action code 8. In such cases a debit/credit pair is not required. For inpatient bills, a 'P' should be entered in the nonpayment code.)

1 FI_NUM_TB — Fiscal Intermediary Number Table

00010 = Alabama BC
00020 = Arkansas BC
00030 = Arizona BC
00040 = California BC (term. 12/00)
00050 = New Mexico BC/CO
00060 = Connecticut BC
00070 = Delaware BC - terminated 2/98
00080 = Florida BC
00090 = Florida BC
00101 = Georgia BC
00121 = Illinois - HCSC
00123 = Michigan - HCSC
00130 = Indiana BC/Administar Federal
00131 = Illinois - Administar
00140 = Iowa - Wellmark (term. 6/2000)
00150 = Kansas BC
00160 = Kentucky/Administar
00180 = Maine BC
00181 = Maine BC - Massachusetts
00190 = Maryland BC
00200 = Massachusetts BC - terminated 7/97
00210 = Michigan BC - terminated 9/94
00220 = Minnesota BC
00230 = Mississippi BC
00231 = Mississippi BC/LA
00232 = Mississippi BC
00241 = Missouri BC - terminated 9/92
00250 = Montana BC
00260 = Nebraska BC
00270 = New Hampshire/VT BC
00280 = New Jersey BC (term. 8/2000)
00290 = New Mexico BC - terminated 11/95
00308 = Empire BC
00310 = North Carolina BC

00320 = North Dakota BC
00332 = Community Mutual Ins Co; Ohio-Administar
00340 = Oklahoma BC
00350 = Oregon BC
00351 = Oregon BC/ID.
00355 = Oregon-CWF
00362 = Independence BC - terminated 8/97
00363 = Veritus, Inc (PITTS)
00370 = Rhode Island BC
00380 = South Carolina BC
00390 = Tennessee BC
00400 = Texas BC
00410 = Utah BC
00423 = Virginia BC; Trigon
00430 = Washington/Alaska BC
00450 = Wisconsin BC
00452 = Michigan - Wisconsin BC
00454 = United Government Services -
Wisconsin BC (eff. 12/00)
00460 = Wyoming BC
00468 = N Carolina BC/CPRTIVA
00993 = BC/BS Assoc.
17120 = Hawaii Medical Service

1 FI_NUM_TB — Fiscal Intermediary Number Table

50333 = Travelers; Connecticut United Healthcare
(terminated - date unknown)
51051 = Aetna California - terminated 6/97
51070 = Aetna Connecticut - terminated 6/97
51100 = Aetna Florida - terminated 6/97
51140 = Aetna Illinois - terminated 6/97
51390 = Aetna Pennsylvania - terminated 6/97
52280 = Mutual of Omaha
57400 = Cooperative, San Juan, PR
61000 = Aetna

1 FI_RQST_CLM_CNCL_RSN_TB — Claim Cancel Reason Code Table

C = Coverage Transfer
D = Duplicate Billing
H = Other or blank
L = Combining two beneficiary master records
P = Plan Transfer
S = Scramble
**********For Action Code 4 **********
*********Effective with HHPPS - 10/00**********
A = RAP/Final claim/LUPA is cancelled by Interme-
diary. Does not delete episode. Do not set
cancellation indicator.
B = RAP/Final claim/LUPA is cancelled by Interme-
diary. Does not delete episode. Set
cancellation indicator to 1.
E = RAP/Final claim/LUPA is cancelled by Interme-
diary. Remove episode.
F = RAP/Final claim/LUPA is cancelled by Provider.

Remove episode.

1 GEO_SSA_STATE_TB State Table

GEO_SSA_STATE_TB

01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin

53 = Wyoming
54 = Africa
55 = Asia
56 = Canada & Islands
57 = Central America and West Indies

1 GEO_SSA_STATE_TB — State Table

58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = U.S. Possessions
64 = American Samoa
65 = Guam
66 = Saipan
97 = Northern Marianas
98 = Guam
99 = With 000 county code is American Samoa; otherwise unknown

1 HCFA_PRVDR_SPCLTY_TB — HCFA Provider Specialty Table

Prior to 5/92

01 = General practice
02 = General surgery
03 = Allergy (revised 10/91 to mean allergy/ immunology)
04 = Otology, laryngology, rhinology revised 10/91 to mean otolaryngology)
05 = Anesthesiology
06 = Cardiovascular disease (revised 10/91 to mean cardiology)
07 = Dermatology
08 = Family practice
09 = Gynecology--osteopaths only (deleted 10/91; changed to '16')
10 = Gastroenterology
11 = Internal medicine
12 = Manipulative therapy (osteopaths only) (revised 10/91 to mean osteopathic manipulative therapy)
13 = Neurology
14 = Neurological surgery (revised 10/91 to mean neurosurgery)
15 = Obstetrics--osteopaths only (deleted 10/91; changed to '16')
16 = OB-gynecology
17 = Ophthalmology, otology, laryngology rhinology--osteopaths only (deleted 10/91; changed to '18' if physicians practice is more than 50% ophthalmology or to '04' if physician's practice is more than 50% otolaryngology. If

practice is 50/50, choose specialty
with greater allowed charges.
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical pathology-
osteopaths only (deleted 10/91;
changed to '22')
22 = Pathology
23 = Peripheral vascular disease or surgery
(deleted 10/91; changed to '76')
24 = Plastic surgery (revised to mean
plastic and reconstructive surgery).
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths only)
(deleted 10/91; changed to '86')
28 = Proctology (revised 10/91 to mean
colorectal surgery).
29 = Pulmonary disease
30 = Radiology (revised 10/91 to mean
diagnostic radiology)
31 = Roentgenology, radiology (osteopaths)
(deleted 10/91; changed to '30')
32 = Radiation therapy--osteopaths (deleted

1	HCFA_PRVDR_SPCLTY_TB	HCFA Provider Specialty Table

10/91; changed to '92')
33 = Thoracic surgery
34 = Urology
35 = Chiropractor, licensed (revised 10/91
to mean chiropractic)
36 = Nuclear medicine
37 = Pediatrics (revised 10/91 to mean
pediatric medicine)
38 = Geriatrics (revised 10/91 to mean
geriatric medicine)
39 = Nephrology
40 = Hand surgery
41 = Optometrist - services related to
condition of aphakia (revised 10/91 to
mean optometrist)
42 = Certified nurse midwife (added 7/88)
43 = Certified registered nurse anesthetist
(revised 10/91 to mean CRNA,
anesthesia assistant)
44 = Infectious disease
46 = Endocrinology (added 10/91)
48 = Podiatry - surgery chiropody (revised
10/91 to mean podiatry)
49 = Miscellaneous (include ASCS)
51 = Medical supply company with C.O.
certification (certified orthotist -
certified by American Board for
Certification in Prosthetics and
Orthotics.
52 = Medical supply company with C.P.

			certification (certified prosthetist - certified by American Board for Certification in Prosthetics and Orthotics).
			53 = Medical supply company with C.P.O. certification (certified prosthetist - orthotist - certified by American Board for Certification in Prosthetics and Orthotics).
			54 = Medical supply company not included in 51, 52, or 53.
			55 = Individual certified orthotist
			56 = Individual certified prosthetist
			57 = Individual certified prosthetist - orthotist
			58 = Individuals not included in 55,56 or 57
			59 = Ambulance service supplier (e.g. private ambulance companies, funeral homes, etc.)
			60 = Public health or welfare agencies (federal, state, and local)
			61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities)
			62 = Psychologist--billing independently
			63 = Portable X-ray supplier--billing independently (revised 10/91 to mean portable X-ray supplier)
			64 = Audiologist (billing independently)
1	HCFA_PRVDR_SPCLTY_TB		HCFA Provider Specialty Table
			65 = Physical therapist (independent practice)
			66 = Rheumatology (added 10/91)
			67 = Occupational therapist--independent practice
			68 = Clinical psychologist
			69 = Independent laboratory--billing independently (revised 10/91 to mean independent clinical laboratory -- billing independently)
			70 = Clinic or other group practice, except Group Practice Prepayment Plan (GPPP)
			71 = Group Practice Prepayment Plan - diagnostic X-ray (do not use after 1/92)
			72 = Group Practice Prepayment Plan - diagnostic laboratory (do not use after 1/92)
			73 = Group Practice Prepayment Plan - physiotherapy (do not use after 1/92)
			74 = Group Practice Prepayment Plan - occupational therapy (do not use after 1/92)
			75 = Group Practice Prepayment Plan - other medical care (do not use after 1/92)
			76 = Peripheral vascular disease (added 10/91)
			77 = Vascular surgery (added 10/91)
			78 = Cardiac surgery (added 10/91)
			79 = Addiction medicine (added 10/91)
			80 = Clinical social worker (1991)

81 = Critical care-intensivists (added 10/91)
82 = Ophthalmology, cataracts specialty
(added 10/91; used only until 5/92)
83 = Hematology/oncology (added 10/91)
84 = Preventive medicine (added 10/91)
85 = Maxillofacial surgery (added 10/91)
86 = Neuropsychiatry (added 10/91)
87 = All other (e.g. drug and department
stores) (revised 10/91 to mean all
other suppliers)
88 = Unknown (revised 10/91 to mean
physician assistant)
90 = Medical oncology (added 10/91)
91 = Surgical oncology (added 10/91)
92 = Radiation oncology (added 10/91)
93 = Emergency medicine (added 10/91)
94 = Interventional radiology (added 10/91)
95 = Independent physiological laboratory
(added 10/91)
96 = Unknown physician specialty
(added 10/91)
99 = Unknown--incl. social worker's
psychiatric services (revised 10/91 to
mean unknown supplier/provider)

Effective 5/92

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology

1 HCFA_PRVDR_SPCLTY_TB HCFA Provider Specialty Table
---

04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Gynecology (osteopaths only)
(discontinued 5/92 use code 16)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative therapy
13 = Neurology
14 = Neurosurgery
15 = Obstetrics (osteopaths only)
(discontinued 5/92 use code 16)
16 = Obstetrics/gynecology
17 = Ophthalmology, otology, laryngology,
rhinology (osteopaths only)
(discontinued 5/92 use codes 18 or 04
depending on percentage of practice)
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical
pathology (osteopaths only)

(discontinued 5/92 use code 22)
22 = Pathology
23 = Peripheral vascular disease, medical or surgical (osteopaths only) (discontinued 5/92 use code 76)
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths only) (discontinued 5/92 use code 86)
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Roentgenology, radiology (osteopaths only) (discontinued 5/92 use code 30)
32 = Radiation therapy (osteopaths only) (discontinued 5/92 use code 92)
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry (revised 10/93 to mean optometrist)
42 = Certified nurse midwife (eff 1/87)
43 = Crna, anesthesia assistant (eff 1/87)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology (eff 5/92)

1	HCFA_PRVDR_SPCLTY_TB	HCFA Provider Specialty Table

47 = Independent Diagnostic Testing Facility (IDTF) (eff. 6/98)
48 = Podiatry
49 = Ambulatory surgical center (formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics)
52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company not included

in 51, 52, or 53. (Revised 10/93
to mean medical supply company for DMERC)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-
orthotist
58 = Individuals not included in 55, 56,
or 57 (revised 10/93 to mean medical
supply company with registered
pharmacist)
59 = Ambulance service supplier, e.G.,
private ambulance companies, funeral
homes, etc.
60 = Public health or welfare agencies
(federal, state, and local)
61 = Voluntary health or charitable
agencies (e.G., National Cancer
Society, National Heart Associiation,
Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (independently
practicing)
66 = Rheumatology (eff 5/92)
Note: during 93/94 DMERC also used this
to mean medical supply company with
respiratory therapist
67 = Occupational therapist (independently
practicing)
68 = Clinical psychologist
69 = Clinical laboratory (billing
independently)
70 = Multispecialty clinic or group
practice
71 = Diagnostic X-ray (GPPP) (not to
be assigned after 5/92)

1	HCFA_PRVDR_SPCLTY_TB	HCFA Provider Specialty Table

72 = Diagnostic laboratory (GPPP)
(not to be assigned after 5/92)
73 = Physiotherapy (GPPP) (not to be
assigned after 5/92)
74 = Occupational therapy (GPPP)
(not to be assigned after 5/92)
75 = Other medical care (GPPP) (not to
assigned after 5/92)
76 = Peripheral vascular disease
(eff 5/92)
77 = Vascular surgery (eff 5/92)
78 = Cardiac surgery (eff 5/92)
79 = Addiction medicine (eff 5/92)
80 = Licensed clinical social worker
81 = Critical care (intensivists)
(eff 5/92)
82 = Hematology (eff 5/92)
83 = Hematology/oncology (eff 5/92)

84 = Preventive medicine (eff 5/92)
85 = Maxillofacial surgery (eff 5/92)
86 = Neuropsychiatry (eff 5/92)
87 = All other suppliers (e.g. drug and
department stores) (note: DMERC used
87 to mean department store from 10/93
through 9/94; recoded eff 10/94 to A7;
NCH cross-walked DMERC reported 87 to A7.
88 = Unknown supplier/provider specialty
(note: DMERC used 87 to mean grocery
store from 10/93 - 9/94; recoded eff
10/94 to A8; NCH cross-walked DMERC
reported 88 to A8.
89 = Certified clinical nurse specialist
90 = Medical oncology (eff 5/92)
91 = Surgical oncology (eff 5/92)
92 = Radiation oncology (eff 5/92)
93 = Emergency medicine (eff 5/92)
94 = Interventional radiology (eff 5/92)
95 = Independent physiological
laboratory (eff 5/92)
96 = Optician (eff 10/93)
97 = Physician assistant (eff 5/92)
98 = Gynecologist/oncologist (eff 10/94)
99 = Unknown physician specialty
A0 = Hospital (eff 10/93) (DMERCs only)
A1 = SNF (eff 10/93) (DMERCs only)
A2 = Intermediate care nursing facility
(eff 10/93) (DMERCs only)
A3 = Nursing facility, other (eff 10/93)
(DMERCs only)
A4 = HHA (eff 10/93) (DMERCs only)
A5 = Pharmacy (eff 10/93) (DMERCs only)
A6 = Medical supply company with respiratory
therapist (eff 10/93) (DMERCs only)
A7 = Department store (for DMERC use:
eff 10/94, but cross-walked from
code 87 eff 10/93)
A8 = Grocery store (for DMERC use:
eff 10/94, but cross-walked from
code 88 eff 10/93)

1	HCFA_PRVDR_SPCLTY_TB	HCFA Provider Specialty Table

1	HCFA_TYPE_SRVC_TB	HCFA Type of Service Table

1 = Medical care
2 = Surgery
3 = Consultation
4 = Diagnostic radiology
5 = Diagnostic laboratory
6 = Therapeutic radiology
7 = Anesthesia
8 = Assistant at surgery
9 = Other medical items or services

0 = Whole blood only eff 01/96,
whole blood or packed red cells before 01/96
A = Used durable medical equipment (DME)
B = High risk screening mammography
(obsolete 1/1/98)
C = Low risk screening mammography
(obsolete 1/1/98)
D = Ambulance (eff 04/95)
E = Enteral/parenteral nutrients/supplies
(eff 04/95)
F = Ambulatory surgical center (facility
usage for surgical services)
G = Immunosuppressive drugs
H = Hospice services (discontinued 01/95)
I = Purchase of DME (installment basis)
(discontinued 04/95)
J = Diabetic shoes (eff 04/95)
K = Hearing items and services (eff 04/95)
L = ESRD supplies (eff 04/95)
(renal supplier in the home before 04/95)
M = Monthly capitation payment for dialysis
N = Kidney donor
P = Lump sum purchase of DME, prosthetics,
orthotics
Q = Vision items or services
R = Rental of DME
S = Surgical dressings or other medical supplies
(eff 04/95)
T = Psychological therapy (term. 12/31/97)
outpatient mental health limitation (eff. 1/1/98)
U = Occupational therapy
V = Pneumococcal/flu vaccine (eff 01/96),
Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),
Pneumococcal only before 04/95
W = Physical therapy
Y = Second opinion on elective surgery
(obsoleted 1/97)
Z = Third opinion on elective surgery
(obsoleted 1/97)

1 LINE_ADDTNL_CLM_DCMTN_IND_TB — Line Additional Claim Documentation Indicator Table

0 = No additional documentation
1 = Additional documentation submitted for
non-DME EMC claim
2 = CMN/prescription/other documentation submitted
which justifies medical necessity
3 = Prior authorization obtained and approved
4 = Prior authorization requested but not approved
5 = CMN/prescription/other documentation submitted
but did not justify medical necessity
6 = CMN/prescription/other documentation submitted
and approved after prior authorization rejected
7 = Recertification CMN/prescription/other
documentation

1 LINE_PLC_SRVC_TB — Line Place Of Service Table

Prior To 1/92

1 = Office
2 = Home
3 = Inpatient hospital
4 = SNF
5 = Outpatient hospital
6 = Independent lab
7 = Other
8 = Independent kidney disease treatment center
9 = Ambulatory
A = Ambulance service
H = Hospice
M = Mental health, rural mental health
N = Nursing home
R = Rural codes

Effective 1/92

11 = Office
12 = Home
21 = Inpatient hospital
22 = Outpatient hospital
23 = Emergency room - hospital
24 = Ambulatory surgical center
25 = Birthing center
26 = Military treatment facility
31 = Skilled nursing facility
32 = Nursing facility
33 = Custodial care facility
34 = Hospice
35 = Adult living care facilities (ALCF) (eff. NYD - added 12/3/97)
41 = Ambulance - land
42 = Ambulance - air or water
50 = Federally qualified health centers (eff. 10/1/93)
51 = Inpatient psychiatric facility
52 = Psychiatric facility partial hospitalization
53 = Community mental health center
54 = Intermediate care facility/mentally retarded
55 = Residential substance abuse treatment facility
56 = Psychiatric residential treatment center
60 = Mass immunizations center (eff. 9/1/97)
61 = Comprehensive inpatient rehabilitation facility
62 = Comprehensive outpatient rehabilitation facility
65 = End stage renal disease treatment facility

71 = State or local public health clinic
72 = Rural health clinic
81 = Independent laboratory

1 LINE_PLC_SRVC_TB — Line Place Of Service Table

99 = Other unlisted facility

1 LINE_PMT_IND_TB — Line Payment Indicator Table

1 = Actual charge
2 = Customary charge
3 = Prevailing charge (adjusted, unadjusted gap fill, etc)
4 = Other (ASC fees, radiology and outpatient limits, and non-payment because of denial.
5 = Lab fee schedule
6 = Physician fee schedule - full fee schedule amount
7 = Physician fee schedule - transition
8 = Clinical psychologist fee schedule
9 = DME and prosthetics/orthotics fee schedules (eff. 4/97)

1 LINE_PRCSG_IND_TB — Line Processing Indicator Table

A = Allowed
B = Benefits exhausted
C = Noncovered care
D = Denied (existed prior to 1991; from BMAD)
I = Invalid data
L = CLIA (eff 9/92)
M = Multiple submittal--duplicate line item
N = Medically unnecessary
O = Other
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided (contractor #88888) - voluntary agreement (eff. 1/98)
R = Reprocessed--adjustments based on subsequent reprocessing of claim
S = Secondary payer
T = MSP cost avoided - IEQ contractor (eff. 7/76)
U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96)
V = MSP cost avoided - litigation settlement (eff. 7/96)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data match project
Z = Bundled test, no payment (eff. 1/1/98)

1 LINE_PRVDR_PRTCPTG_IND_TB — Line Provider Participating Indicator Table

1 = Participating
2 = All or some covered and allowed
    expenses applied to deductible Participating
3 = Assignment accepted/non-participating
4 = Assignment not accepted/non-participating
5 = Assignment accepted but all or some
    covered and allowed expenses applied
    to deductible Non-participating.
6 = Assignment not accepted and all covered
    and allowed expenses applied to deductible
    non-participating.
7 = Participating provider not accepting
    assignment.

1 NCH_CLM_TYPE_TB — NCH Claim Type Table

10 = HHA claim
20 = Non swing bed SNF claim
30 = Swing bed SNF claim
40 = Outpatient claim
41 = Outpatient 'Full-Encounter' claim
     (available in NMUD)
42 = Outpatient 'Abbreviated-Encounter' claim
     (available in NMUD)
50 = Hospice claim
60 = Inpatient claim
61 = Inpatient 'Full-Encounter' claim
62 = Inpatient 'Abbreviated-Encounter claim
     (available in NMUD)
71 = RIC O local carrier non-DMEPOS claim
72 = RIC O local carrier DMEPOS claim
73 = Physician 'Full-Encounter' claim
     (available in NMUD)
81 = RIC M DMERC non-DMEPOS claim
82 = RIC M DMERC DMEPOS claim

1 NCH_EDIT_TB — NCH EDIT TABLE

A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
A000 = (C) REIMB > $100,000 OR UNITS > 150
A002 = (C) CLAIM IDENTIFIER (CAN)
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
A004 = (C) PATIENT SURNAME BLANK
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
A006 = (C) DATE OF BIRTH IS NOT NUMERIC
A007 = (C) INVALID GENDER (0, 1, 2)
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
A1X1 = (C) PERCENT ALLOWED INDICATOR

A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589
A1X3 = (C) DT>96365,DIAG=V725
A1X4 = (C) INVALID DIAGNOSTIC CODES
C050 = (U) HOSPICE - SPELL VALUE INVALID
D102 = (C) DME DATE OF BIRTH INVALID
D2X2 = (C) DME SCREEN SAVINGS INVALID
D2X3 = (C) DME SCREEN RESULT INVALID
D2X4 = (C) DME DECISION IND INVALID
D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
D3X1 = (C) DME NATIONAL DRUG CODE INVALID
D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
D4X2 = (C) DME OUT OF DMERC SERVICE AREA
D4X3 = (C) DME STATE CODE INVALID
D5X1 = (C) TOS INVALID FOR DME HCPCS
D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING
D5X3 = (C) DME INVALID USE OF MS MODIFIER
D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
D6X1 = (C) DME SUPPLIER NUMBER MISSING
D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6
XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
Y003 = (C) HCPCS R0075/UNITS=SERVICES
Y010 = (C) TOB=13X/14X AND T.C.>$7,500
Y011 = (C) INP CLAIM/REIM > $75,000
Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
Z002 = (C) CC M2 PRESENT/REIMB > $150,000
Z003 = (C) CC M2 PRESENT/UNITS > 150
Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
Z005 = (C) REIMB>99999 AND REIMB<150000
Z006 = (C) UNITS>99 AND UNITS<150
Z237 = (E) HOSPICE OVERLAP - DATE ZERO
0011 = (C) ACTION CODE INVALID
0013 = (C) CABG/PCOE AND INVALID ADMIT DATE
0014 = (C) DEMO NUM NOT=01-06,08,15,31
0015 = (C) ESRD PLAN BUT DEMO ID NOT = 15
0016 = (C) INVALID VA CLAIM
0017 = (C) DEMO=31,TOB<>11 OR SPEC<>08
0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
0020 = (C) CANCEL ONLY CODE INVALID
0021 = (C) DEMO COUNT > 1
0301 = (C) INVALID HI CLAIM NUMBER

1 NCH_EDIT_TB NCH EDIT TABLE
---------- --------------

0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
0401 = (C) BILL TYPE/PROVIDER INVALID
0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092
0407 = (C) RESPITE CARE BILL TYPE 34X,NO REV 66
0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636

0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS
0414 = (C) VALU CD 61,MSA AMOUNT MISSING
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
05X5 = (C) UPIN REQUIRED FOR DME HCPCS
0501 = (C) UNIQUE PHY IDEN. (UPIN) BLANK
0502 = (C) UNIQUE PHY IDEN. (UPIN) INVALID
0601 = (C) GENDER INVALID
0701 = (C) CONTRACTOR INVALID CARRIER/ETC
0702 = (C) PROVIDER NUMBER INCONSISTANT
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
0704 = (C) INVALID CONT FOR CABG DEMO
0705 = (C) INVALID CONT FOR PCOE DEMO
0901 = (C) INVALID DISP CODE OF 02
0902 = (C) INVALID DISP CODE OF SPACES
0903 = (C) INVALID DISP CODE
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
1301 = (C) LINE COUNT NOT NUMERIC OR > 13
1302 = (C) RECORD LENGTH INVALID
1401 = (C) INVALID MEDICARE STATUS CODE
1501 = (C) ADMIT DATE/ENTRY CODE INVALID
1502 = (C) ADMIT DATE > STAY FROM DATE
1503 = (C) ADMIT DATE INVALID WITH THRU DATE
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
1505 = (C) HCPCS W SERVICE DATES > 09-30-94
1601 = (C) INVESTIGATION IND INVALID
1701 = (C) SPLIT IND INVALID
1801 = (C) PAY-DENY CODE INVALID
1802 = (C) HEADER AMT AND NOT DENIED CLAIM
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
1901 = (C) AB CROSSOVER IND INVALID
2001 = (C) HOSPICE OVERRIDE INVALID
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
2102 = (C) FROM/THRU DATE OR KRON/PAT STAT
2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL
2202 = (C) STAY-FROM DATE > THRU-DATE
2203 = (C) THRU DATE INVALID
2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
2207 = (C) MAMMOGRAPHY BEFORE 1991
2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
2302 = (C) COVERED DAYS INVALID OR INCONSIST
2303 = (C) COST REPORT DAYS > ACCOMIDATION
2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL
2305 = (C) UTIL DAYS = INCONSISTENCIES
2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09

1 NCH_EDIT_TB — NCH EDIT TABLE

2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
2401 = (C) NON-UTIL DAYS INVALID
2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL
2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
2504 = (C) COINSURANCE AMOUNT EXCESSIVE

2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
2508 = (C) COINSURANCE DAYS INVALID FOR TRAN
2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
2604 = (C) PPS BILL, NO DAY OUTLIER
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
28XA = (C) UTIL DAYS > FROM TO BENEF EXH
28XB = (C) BENEFITS EXH DATE > FROM DATE
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE
28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES
28X1 = (C) OCCUR DATE INVALID
28X2 = (C) OCCUR = 20 AND TRANS = 4
28X3 = (C) OCCUR 20 DATE < ADMIT DATE
28X4 = (C) OCCUR 20 DATE > ADMIT + 12
28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM
28X6 = (C) OCCUR 20 DATE < BENE EXH DATE
28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
28X8 = (C) OCCUR 22 DATE < FROM OR > THRU
28X9 = (C) UTIL > FROM - THRU LESS NCOV
33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)
33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)
33X3 = (C) QS DAYS/ADMISSION ARE INVALID
33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)
33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE
33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091
33X7 = (C) TOB<>18/21/28/51,COND=WO
33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001
33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
3401 = (C) DEMO ID = 04 AND RIC NOT = 1
35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS
35X2 = (C) COND = 60 OR 61 AND NO VALU 17
35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0
36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU
3701 = (C) ASSIGN CODE INVALID
3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA
3706 = (C) INVALID IDE NUMBER-NOT IN FILE
3710 = (C) NUM OF IDE# > REV 0624
3715 = (C) NUM OF IDE# < REV 0624
3720 = (C) IDE AND LINE ITEM NUMBER > 2
3801 = (C) AMT BENE PD INVALID
4001 = (C) BLOOD PINTS FURNISHED INVALID
4002 = (C) BLOOD FURNISHED/REPLACED INVALID

1 NCH_EDIT_TB NCH EDIT TABLE
---------- --------------

4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
4201 = (C) BLOOD PINTS UNREPLACED INVALID
4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED

4203 = (C) INVALID CPO PROVIDER NUMBER
4301 = (C) BLOOD DEDUCTABLE INVALID
4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
4304 = (C) BLOOD DEDUCT > 3 - REPLACED
4501 = (C) PRIMARY DIAGNOSIS INVALID
46XA = (C) MSP VET AND VET AT MEDICARE
46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
46XG = (C) VALU CODE 20 INVALID
46XN = (C) VALUE CODE 37,38,39 INVALID
46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG
46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS
46XQ = (C) VALUE CDE 37=39 AND 38 IS PRESENT
46XR = (C) BLD FIELDS VS REV CDE 380,381,382
46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
46XT = (C) CABG/PCOE,VC<>Y1,Y2,Y3,Y4,VA NOT>0
46X1 = (C) VALUE AMOUNT INVALID
46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
46X7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
4601 = (C) CABG/PCOE, MSP CODE PRESENT
4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
4901 = (C) PCOE/CABG,DEN CD NOT D
4902 = (C) PCOE/CABG BUT DME
50X1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
50X2 = (C) REV CD=054X,MOD NOT = QM,QN
5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
51XA = (C) HCPCS EYEWARE & REV CODE NOT 274
51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51XD = (C) HCPCS REQUIRES UNITS > ZERO
51XE = (C) HCPCS REQUIRES REVENUE CODE 636
51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
51XH = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
51XI = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045
51XJ = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
51XK = (C) TOB 21X/P82=2/3/4,REV CD = NNX
51XL = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
51XM = (C) 21X,RC>9041/<9045,RC<>4/234
51XN = (C) 21X,RC>9032/<9042,RC<>4/234
51XP = (C) HHA RC DATE OF SRVC MISSING
51XQ = (C) NO RC 0636 OR DTE INVALID
51XR = (C) DEMO ID=01,RIC NOT=2
51XS = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
51X0 = (C) REV CENTER CODE INVALID
51X1 = (C) REV CODE CHECK

1 NCH_EDIT_TB — NCH EDIT TABLE

51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
51X3 = (C) UNITS MUST BE > 0
51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
51X9 = (C) HCPCS/REV CODE/BILL TYPE
5100 = (U) TRANSITION SPELL / SNF
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
5169 = (U) PROVIDER NE TO WORK PROVIDER
5177 = (U) PROVIDER NE TO WORK PROVIDER
5178 = (U) HOSPICE BILL THRU < DOLBA
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
5200 = (E) ENTITLEMENT EFFECTIVE DATE
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
5202 = (U) HOSPICE TRAILER ERROR
5203 = (E) ENTITLEMENT HOSPICE PERIODS
5203 = (U) HOSPICE START DATE ERROR
5204 = (U) HOSPICE DATE DIFFERENCE NE 90
5205 = (U) HOSPICE DATE DISCREPANCY
5206 = (U) HOSPICE DATE DISCREPANCY
5207 = (U) HOSPICE THRU > TERM DATE 2ND
5208 = (U) HOSPICE PERIOD NUMBER BLANK
5209 = (U) HOSPICE DATE DISCREPANCY
5210 = (E) ENTITLEMENT FRM/TRU/END DATES
5211 = (E) ENTITLEMENT DATE DEATH/THRU
5212 = (E) ENTITLEMENT DATE DEATH/THRU
5213 = (E) ENTITLEMENT DATE DEATH MBR
5220 = (E) ENTITLEMENT FROM/EFF DATES
5225 = (E) ENT INP PPS SPAN 70 DATES
5232 = (E) ENTL HMO NO HMO OVERRIDE CDE
5233 = (E) ENTITLEMENT HMO PERIODS
5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
5236 = (E) ENTITLEMENT HMO HOSP + CC07
5237 = (E) ENTITLEMENT HOSP OVERLAP
5238 = (U) HOSPICE CLAIM OVERLAP > 90
5239 = (U) HOSPICE CLAIM OVERLAP > 60
524Z = (E) HOSP OVERLAP NO OVD NO DEMO
5240 = (U) HOSPICE DAYS STAY+USED > 90
5241 = (U) HOSPICE DAYS STAY+USED > 60
5242 = (C) INVALID CARRIER FOR RRB
5243 = (C) HMO=90091,INVALID SERVICE DTE
5244 = (E) DEMO CABG/PCOE MISSING ENTL
5245 = (C) INVALID CARRIER FOR NON RRB
525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO
5250 = (U) HOSPICE DOEBA/DOLBA
5255 = (U) HOSPICE DAYS USED
5256 = (U) HOSPICE DAYS USED > 999
526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
5299 = (U) HOSPICE PERIOD NUMBER ERROR

5320 = (U) BILL > DOEBA AND IND-1 = 2
5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
5355 = (U) HOSPICE DAYS USED SECONDARY
5378 = (C) SERVICE DATE < AGE 50
5399 = (U) HOSPICE PERIOD NUM MATCH
5410 = (U) INPAT DEDUCTABLE
5425 = (U) PART B DEDUCTABLE CHECK
5430 = (U) PART B DEDUCTABLE CHECK
5450 = (U) PART B COMPARE MED EXPENSE
5460 = (U) PART B COMPARE MED EXPENSE
5499 = (U) MED EXPENSE TRAILER MISSING
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
5510 = (U) COIN DAYS/SNF COIN DAYS
5515 = (U) FULL DAYS/COIN DAYS
5516 = (U) SNF FULL DAYS/SNF COIN DAYS
5520 = (U) LIFE RESERVE DAYS
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
5540 = (U) HH VISITS NE AFT PT B TRLR
5550 = (E) SNF LESS THAN PT A EFF DATE
5600 = (D) LOGICAL DUPE, COVERED
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
5602 = (D) LOGICAL DUPE, PANDE C, E OR I
5603 = (D) LOGICAL DUPE, COVERED
5605 = (D) POSS DUPE, OUTPAT REIMB
5606 = (D) POSS DUPE, HOME HEALTH COVERED U
5623 = (U) NON-PAY CODE IS P
57X1 = (C) PROVIDER SPECIALITY CODE INVALID
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID
5700 = (U) LINKED TO THREE SPELLS
5701 = (C) DEMO ID=02,RIC NOT = 5
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
58X1 = (C) PROVIDER TYPE INVALID
58X9 = (C) TYPE OF SERVICE INVALID
5802 = (C) REIMB > $150,000
5803 = (C) UNITS/VISITS > 150
5804 = (C) UNITS/VISITS > 99
59XA = (C) PROST ORTH HCPCS/FROM DATE
59XB = (C) HCPCS/FROM DATE/TYPE P OR I
59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE
59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS
59XG = (C) CAPPED/FREQ-MAINT/PROST HCPCS
59XH = (C) HCPCS E0620/TYPE/DATE
59XI = (C) HCPCS E0627-9/ DATE < 1991
59XL = (C) HCPCS 00104 - TOS/POS
59X1 = (C) INVALID HCPCS/TOS COMBINATION
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
59X3 = (C) TOS INVALID TO MODIFIER
59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
59X5 = (C) MAMMOGRAPHY FOR MALE
59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
59X7 = (C) CAPPED-HCPCS/FROM DATE
59X8 = (C) FREQUENTLY MAINTAINED HCPCS

59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
5901 = (U) ERROR CODE OF Q
60X1 = (C) ASSIGN IND INVALID

6000 = (U) ADJUSTMENT BILL SPELL DATA
6020 = (U) CURRENT SPELL DOEBA < 1990
6030 = (U) ADJUSTMENT BILL SPELL DATA
6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
61X1 = (C) PAY PROCESS IND INVALID
61X2 = (C) DENIED CLAIM/NO DENIED LINE
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
61X4 = (C) RATE MISSING OR NON-NUMERIC
6100 = (C) REV 0001 NOT PRESENT ON CLAIM
6101 = (C) REV COMPUTED CHARGES NOT=TOTAL
6102 = (C) REV COMPUTED NON-COVERED/NON-COV
6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
62XA = (C) PSYC OT PT/REIM/TYPE
62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
62X8 = (C) KIDNEY DONO/TYPE/100%
62X9 = (C) PNEUM VACCINE/TYPE/100%
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
6261 = (U) HOSPICE ADJUSTMENT DAYS USED
6265 = (U) HOSPICE ADJUSTMENT DAYS USED
6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
63X1 = (C) DEDUCT IND INVALID
63X2 = (C) DED/HCFA COINS IN PCOE/CABG
6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
64X1 = (C) PROVIDER IND INVALID
6430 = (U) PART B DEDUCTABLE CHECK
65X1 = (C) PAYSCREEN IND INVALID
66?? = (D) POSS DUPE, CR/DB, DOC-ID
66XX = (D) POSS DUPE, CR/DB, DOC-ID
66X1 = (C) UNITS AMOUNT INVALID
66X2 = (C) UNITS IND > 0; AMT NOT VALID
66X3 = (C) UNITS IND = 0; AMT > 0
66X4 = (C) MT INDICATOR/AMOUNT
6600 = (U) ADJUSTMENT BILL FULL DAYS
6610 = (U) ADJUSTMENT BILL COIN DAYS
6620 = (U) ADJUSTMENT BILL LIFE RESERVE
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
67X1 = (C) UNITS INDICATOR INVALID
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
68X1 = (C) INVALID HCPCS CODE
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092

68X3 = (C) TYPE OF SERVICE = G /PROC CODE
68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE
68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
68X8 = (C) LINE ITEM INCORRECT OR DATE INVAL.

69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
69X3 = (C) PROC CODE MOD = LL / TYPE = R
69X6 = (C) PROC CODE MOD/NOT CAPPED
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO
6902 = (C) KRON IND AND NO-PAY CODE B OR N
6903 = (C) KRON IND AND INPATIENT DEDUCT = 0
6904 = (C) KRON IND AND TRANS CODE IS 4
6910 = (C) REV CODES ON HOME HEALTH
6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY
6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO
6913 = (C) REV CODE INVAL FOR OXYGEN
6914 = (C) REV CODE INVAL FOR DME
6915 = (C) PURCHASE OF RENT DME INVAL ON DATES
6916 = (C) PURCHASE OF RENT DME INVAL ON DATES
6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000
6918 = (C) HCPCS INVALID ON DATE RANGES
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291
6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL
6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X
6929 = (U) ADJUSTMENT BILL LIFE RESERVE
6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
7000 = (U) INVALID DOEBA/DOLBA
7002 = (U) LESS THAN 60/61 BETWEEN SPELLS
7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD
71X1 = (C) SUBMITTED CHARGES INVALID
71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG
72X1 = (C) ALLOWED CHGS INVALID
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
72X3 = (C) DENIED LINE/ALLOWED CHARGES
73X1 = (C) SS NUMBER INVALID
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL
77X1 = (C) PLACE OF SERVICE INVALID
77X2 = (C) PHYS THERAPY/PLACE
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND
77X6 = (C) TOS=F, PL OF SER NOT = 24
7701 = (C) INCORRECT MODIFIER
7777 = (D) POSS DUPE, PART B DOC-ID
78XA = (C) MAMMOGRAPHY BEFORE 1991
78X1 = (C) THRU DATE INVALID
78X3 = (C) FROM DATE GREATER THAN THRU DATE
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY

78X5 = (C) FROM DATE > PAID DATE/TYPE/100%
78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE
79X3 = (C) THRU DATE>RECD DATE/NOT DENIED
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90
8028 = (E) NO ENTITLEMENT
8029 = (U) HH BEFORE PERIOD NOT PRESENT
8030 = (U) HH BILL VISITS > PT A REMAINING
8031 = (U) HH PT A REMAINING > 0

1 NCH_EDIT_TB NCH EDIT TABLE

8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
8050 = (U) HH QUALIFYING INDICATOR = 1
8051 = (U) HH # VISITS NE AFT PT B APPLIED
8052 = (U) HH # VISITS NE AFT TRAILER
8053 = (U) HH BENEFIT PERIOD NOT PRESENT
8054 = (U) HH DOEBA/DOLBA NOT > 0
8060 = (U) HH QUALIFYING INDICATOR NE 1
8061 = (U) HH DATE NE DOLBA IN AFT TRLR
8062 = (U) HH NE PT-A VISITS REMAINING
81X1 = (C) NUM OF SERVICES INVALID
83X1 = (C) DIAGNOSIS INVALID
8301 = (C) HCPCS/GENDER DIAGNOSIS
8302 = (C) HCPCS G0101 V-CODE/SEX CODE
8304 = (C) BILL TYPE INVALID FOR G0123/4
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
84X2 = (C) INVALID DME START DATE
84X3 = (C) INVALID DME START DATE W/HCPCS
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
84X5 = (C) HCPCS CODE WITH INV DIAG CODE
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC
9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT DEDUCTABLE CALC
9040 = (U) DATA INDICATOR 1 SET
9050 = (U) DATA INDICATOR 2 SET
91X1 = (C) PATIENT REIMB/PAY-DENY CODE
92X1 = (C) PATIENT REIMB INVALID
92X2 = (C) PROVIDER REIMB INVALID
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
92X7 = (C) REIMB/PAY-DENY INCONSISTANT
9201 = (C) UPIN REF NAME OR INITIAL MISSING
9202 = (C) UPIN REF FIRST 3 CHAR INVALID
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
93X1 = (C) CASH DEDUCTABLE INVALID
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
93X4 = (C) FROM DATE/CASH DEDUCTIBLE
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9300 = (C) UPIN OTHER, NOT PRESENT
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM

9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) PR-PSYCH DAYS INVALID
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
94G1 = (C) NO-PAY CODE INVALID

94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
94G4 = (C) NO PAY CODE = R & REIMB PRESENT
94X1 = (C) BLOOD LIMIT INVALID
94X2 = (C) TYPE/BLOOD DEDUCTIBLE
94X3 = (C) TYPE/DATE/LIMIT AMOUNT
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
9401 = (C) BLOOD DEDUCTIBLE AMT > 3
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
9404 = (C) INVALID GENDER CODE ON PRO-PAY
9407 = (C) INVALID DRG NUMBER
9408 = (C) INVALID DRG NUMBER (GLOBAL)
9409 = (C) HCFA DRG<>DRG ON BILL
9410 = (C) CABG/PCOE,INVALID DRG
95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
95X2 = (C) MSP AMOUNT APPLIED INVALID
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
95X5 = (C) MSP CODE = G/DATE BEFORE 1987
95X6 = (C) MSP CODE = X AND NOT AVOIDED
95X7 = (C) MSP CODE VALID, CABG/PCOE
96X1 = (C) OTHER AMOUNTS INVALID
96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0
98X1 = (C) COINSURANCE INVALID
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
99XX = (D) POSS DUPE, PART B DOC-ID
9901 = (C) REV CODE INVALID OR TRAILER CNT=0
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
9903 = (C) NO CLINIC VISITS FOR RHC
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
991X = (C) NO DATE OF SERVICE
9910 = (C) EDIT 9910 (NEW)
9911 = (C) BLOOD VERIFIED INVALID
9920 = (C) EDIT 9920 (NEW)
9930 = (C) EDIT 9930 (NEW)
9931 = (C) OUTPAT COINSURANCE VALUES
9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT

9940 = (C) EDIT 9940 (NEW)
9942 = (C) EDIT 9942 (NEW)
9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
9945 = (C) SERVICE DATE < 98001
9946 = (C) INVALID DIAGNOSIS CODE
9947 = (C) INVALID DIAGNOSIS CODE
9948 = (C) STAY FROM>96365,DIAG=V725
9960 = (C) MED CHOICE BUT HMO DATA MISSING
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER

1 NCH_IP_PRO_APRVL_TYPE_TB — NCH Inpatient Peer Review Organization Approval Type Table

1 = Approved by the PRO as billed - Code indicates that the claim has been reviewed by the PRO and has been fully approved including any day or cost outliers.
2 = Automatic approval - Does not apply to Medicare claim.
3 = Partial approval - Code indicates the bill has been reviewed by the PRO, and some portion (days or services) has been denied. The from/thru dates of the approved portion of the stay, excluding grace days and any period at a noncovered level of care are shown on the bill.
4 = Admission denied - Code indicates the patient's need for inpatient services was reviewed upon admission and the PRO found that the stay was not medically necessary.
5 = Post payment review - Code indicates that any medical review will be completed after the claim is paid. The bill may be a day outlier, part of the sample review, or may not be reviewed.
6 = Pre-admission authorization - Pre-admission authorization obtained, but services not reviewed by the PRO.
7 THRU 9 = Reserved.

1 NCH_NEAR_LINE_RIC_TB — NCH Near-Line Record Identification Code Table

O = Part B physician/supplier claim record (processed by local carriers; can include DMEPOS services)
V = Part A institutional claim record (inpatient (IP), skilled nursing facility (SNF), christian science (CS), home health agency (HHA), or hospice)

W = Part B institutional claim record
(outpatient (OP), HHA)
U = Both Part A and B institutional home
health agency (HHA) claim records --
due to HHPPS and HHA A/B split.
(effective 10/00)
M = Part B DMEPOS claim record (processed
by DME Regional Carrier) (effective 10/93)

1 NCH_PATCH_TB — NCH Patch Table

01 = RRB Category Equatable BIC - changed (all claim types) -- applied during the Nearline 'G' conversion to claims with NCH weekly process date before 3/91. Prior to Version 'H', patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 2.
02 = Claim Transaction Code made consistent with NCH payment/edit RIC code (OP and HHA) -- effective 3/94, CWFMQA began patch. During 'H' conversion, patch applied to claims with NCH weekly process date prior to 3/94. Prior to version 'H', patch indicator stored in redefined Claim Edit Group, 4th occurrence, position 1.
03 = Garbage/nonnumeric Claim Total Charge Amount set to zeroes (Instnl) -- during the Version 'G' conversion, error occurred in the derivation of this field where the claim was missing revenue center code = '0001'. In 1994, patch was applied to the OP and HHA SAFs only. (This SAF patch indicator was stored in the redefined Claim Edit Group, 4th occurrence, position 2). During the 'H' ocnversion, patch applied to Nearline claims where garbage or nonnumeric values.
04 = Incorrect bene residence SSA standard county code '999' changed (all claim types) -- applied during the Nearline 'G' conversion and ongoing through 4/21/94, calling EQSTZIP routine to claims with NCH weekly process date prior to 4/22/94. Prior to Version 'H' patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 4.
05 = Wrong century bene birth date corrected (all claim types) -- applied during Nearline 'H' conversion to all history where century greater than 1700 and less than 1850; if century less than 1700, zeroes moved.
06 = Inconsistent CWF bene medicare status code made consistent with age (all claim types) -- applied during Nearline 'H' conversion to all history and patched ongoing. Bene age is calculated to determine the correct value; if greater than 64, 1st position MSC ='1'; if less than 65, 1st position MSC = '2'.

07 = Missing CWF bene mediare status code derived (all claim types) -- applied during Nearline 'H' conversion to all history and patched ongoing, except claims with unknown DOB and/ or Claim From Date='0' (left blank). Bene age is calculated to determine missing value; if greater than 64, MSC='10'; if less than 65, MSC = '20'.

08 = Invalid NCH primary payer code set to blanks (Instnl) -- applied during Version 'H' conversion to claims with NCH weekly process date 10/1/93-10/30/95, where MSP values =

1	NCH_PATCH_TB		NCH Patch Table
	----------		---

invalid '0', '1', '2', '3' or '4' (caused by erroneous logic in HCFA program code, which was corrected on 11/1/95).

09 = Zero CWF claim accretion date replaced with NCH weekly process date (all claim types) -- applied during Version 'H' conversion to Instnl and DMERC claims; applied during Version 'G' conversion to non-institutional (non-DMERC) claims. Prior to Version 'H', patch indicator stored in redefined claim edit group, 3rd occurrence, position 1.

10 = Multiple Revenue Center 0001 (Outpatient, HHA and Hospice) -- patch applied to 1998 & 1999 Nearline and SAFs to delete any revenue codes that followed the first '0001' revenue center code. The edit was applied across all institutional claim types, including Inpatient/ SNF (the problem was only found with OP/HHA/ Hospice claims). The problem was corrected 6/25/99.

11 = Truncated claim total charge amount in the fixed portion replaced with the total charge amount in the revenue center 0001 amount field -- service years 1998 & 1999 patched during quarterly merge. The 1998 & 1999 SAFs were corrected when finalized in 7/99. The patch was done for records with NCH Daily Process Date 1/4/99 - 5/14/99.

12 = Missing claim-level HHA Total Visit Count -- service years 1998, 1999 & 2000 patch applied during Version 'I' conversion of both the Nearline and SAFs. Problem occurs in those claims recovered during the missing claims effort.

13 = Inconsistent Claim MCO Paid Switch made consistent with criteria used to identify an inpatient encounter claim -- if MCO paid switch equal to blank or '0' and ALL conditions are met to indicate an inpatient encounter claim (bene enrolled in a risk MCO during the service period), change the switch to a '1'. The patch was applied during the Version 'I' conversion, for claims back to 7/1/97 service thru date.

1 NCH_STATE_SGMT_TB — NCH State Segment Table

01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennesee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa

55 = Asia
56 = Canada
57 = Central America & West Indies

1 NCH_STATE_SGMT_TB — NCH State Segment Table

58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = US Possessions
97 = Saipan - MP
98 = Guam
99 = American Samoa

1 PRVDR_NUM_TB — Provider Number Table

- First two positions are the GEO SSA State Code.
  Exception: 55 = California
  67 = Texas
  68 = Florida

- Positions 3 and sometimes 4 are used as a category identifier. The remaining positions are serial numbers. The following blocks of numbers are reserved for the facilities indicated (NOTE: may have different meanings dependent on the Type of Bill (TOB):

0001-0879	Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X
0880-0899	Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X
0900-0999	Multiple hospital component in a medical complex (numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1000-1199	Reserved for future use
1200-1224	Alcohol/drug hospitals (excluded from PPS-numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1225-1299	Medical assistance facilities (Montana project); ESRD clinic where TOB = 72X
1300-1399	Rural Primary Care Hospital (RCPH) - eff. 10/97 changed to Critical Access Hospitals (CAH)
1400-1499	Continuation of 4900-4999 series (CMHC)
1500-1799	Hospices
1800-1989	Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP PTB)

	where TOB = 22X; HHA where TOB = 32X, 33X, 34X
1990-1999	Christian Science Sanatoria (hospital services)
2000-2299	Long-term hospitals (excluded from PPS)
2300-2499	Chronic renal disease facilities (hospital based)
2500-2899	Non-hospital renal disease treatment centers
2900-2999	Independent special purpose renal dialysis facility (1)
3000-3024	Formerly tuberculosis hospitals (numbers retired)
3025-3099	Rehabilitation hospitals (excluded from PPS)
3100-3199	Continuation of Subunits of Nonprofit and Proprietary Home Health Agencies (7300-7399) Series (3) (eff. 4/96)
3200-3299	Continuation of 4800-4899 series (CORF)
3300-3399	Children's hospitals (excluded from PPS) where TOB = 11X; ESRD clinic where TOB = 72X
3400-3499	Continuation of rural health clinics (provider-based) (3975-3999)
3500-3699	Renal disease treatment centers (hospital satellites)
3700-3799	Hospital based special purpose renal dialysis facility (1)
3800-3974	Rural health clinics (free-standing)
3975-3999	Rural health clinics (provider-based)
4000-4499	Psychiatric hospitals (excluded from PPS)
4500-4599	Comprehensive Outpatient Rehabilitation Facilities (CORF)
4600-4799	Community Mental Health Centers (CMHC); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X
4800-4899	Continuation of 4500-4599 series (CORF) (eff. 10/95)
4900-4999	Continuation of 4600-4799 series (CMHC) (eff. 10/95); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X
5000-6499	Skilled Nursing Facilities
6500-6989	CMHC / Outpatient physical therapy services where TOB = 74X; CORF where TOB = 75X
6990-6999	Christian Science Sanatoria (skilled nursing services)
7000-7299	Home Health Agencies (HHA) (2)
7300-7399	Subunits of 'nonprofit' and 'proprietary' Home Health Agencies (3)
7400-7799	Continuation of 7000-7299 series
7800-7999	Subunits of state and local governmental Home Health Agencies (3)
8000-8499	Continuation of 7400-7799 series (HHA)

8500-8899 Continuation of rural health center (provider based) (3400-3499)
8900-8999 Continuation of rural health center (free-standing) (3800-3974)
9000-9499 Continuation of 8000-8499 series (HHA) (eff. 10/95)
9500-9999 Reserved for future use (eff. 8/1/98) NOTE: 10/95-7/98 this series was assigned to HHA's but rescinded - no HHA's were ever assigned a number from this series.

Exception:

P001-P999 Organ procurement organization

(1) These facilities (SPRDFS) will be assigned the same provider number whenever they are recertified.

(2) The 6400-6499 series of provider numbers in Iowa (16), South Dakota (43) and Texas (45)

have been used in reducing acute care costs (RACC) experiments.

(3) In Virginia (49), the series 7100-7299 has been reserved for statewide subunit components of the Virginia state home health agencies.

(4) Parent agency must have a number in the 7000-7299, 7400-7799 or 8000-8499 series.

NOTE:
There is a special numbering system for units of hospitals that are excluded from prospective payment system (PPS) and hospitals with SNF swing-bed designation. An alpha character in the third position of the provider number identifies the type of unit or swing-bed designation as follows:

S = Psychiatric unit (excluded from PPS)
T = Rehabilitation unit (excluded from PPS)
U = Short term/acute care swing-bed hospital
V = Alcohol drug unit (prior to 10/87 only)
W = Long term SNF swing-bed hospital (eff 3/91)
Y = Rehab hospital swing-bed (eff 9/92)
Z = Rural primary care swing-bed hospital

There is also a special numbering system for assigning emergency hospital identification numbers (non participating hospitals). The sixth position of the provider number is as follows:

E = Non-federal emergency hospital
F = Federal emergency hospital

1 PTNT_DSCHRG_STUS_TB — Patient Discharge Status Table

01 = Discharged to home/self care (routine charge).
02 = Discharged/transferred to other short term general hospital for inpatient care.
03 = Discharged/transferred to skilled nursing facility (SNF) - (For hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF.
04 = Discharged/transferred to intermediate care facility (ICF).
05 = Discharged/transferred to another type of institution for inpatient care (including distinct parts).
06 = Discharged/transferred to home care of organized home health service organization.
07 = Left against medical advice or discontinued care.
08 = Discharged/transferred to home under care of a home IV drug therapy provider.
09 = Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
20 = Expired (did not recover - Christian Science patient).
30 = Still patient.
40 = Expired at home (hospice claims only)
41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
42 = Expired - place unknown (Hospice claims only)
50 = Hospice - home (eff. 10/96)
51 = Hospice - medical facility (eff. 10/96)
61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (to be implemented in 1999)
71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (to be implemented in 1999).
72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (to be implemented in 1999).

1 REV_CNTR_ANSI_TB — Revenue Center ANSI Code Table

*******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******
**************POSITIONS 1 & 2 OF ANSI CODE***************

CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals -- this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA = Other Adjustments -- this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions -- this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

***********Claim Adjustment Reason Codes**************
***********POSITIONS 3 through 5 of ANSI CODE**********

1 = Deductible Amount
2 = Coinsurance Amount
3 = Co-pay Amount
4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.
5 = The procedure code/bill type is inconsistent with the place of service.
6 = The procedure code is inconsistent with the patient's age.
7 = The procedure code is inconsistent with the patient's gender.
8 = The procedure code is inconsistent with the provider type.
9 = The diagnosis is inconsistent with the patient's age.
10 = The diagnosis is inconsistent with the patient's gender.
11 = The diagnosis is inconsistent with the procedure.
12 = The diagnosis is inconsistent with the provider type.
13 = the date of death precedes the date of service.
14 = The date of birth follows the date of service.

15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
16 = Claim/service lacks information which is needed for adjudication.
17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.
18 = Duplicate claim/service.
19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20 = Claim denied because this injury/illness is covered by the liability carrier.
21 = Claim denied because this injury/illness is the liability of the no-fault carrier.
22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.
23 = Claim adjusted because charges have been paid by another payer.
24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25 = Payment denied. Your Stop loss deductible has not been met.
26 = Expenses incurred prior to coverage.
27 = Expenses incurred after coverage terminated.
28 = Coverage not in effect at the time the service was provided.
29 = The time limit for filing has expired.
30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31 = Claim denied as patient cannot be identified as our insured.
32 = Our records indicate that this dependent is not an eligible dependent as defined.
33 = Claim denied. Insured has no dependent coverage.
34 = Claim denied. Insured has no coverage for newborns.
35 = Benefit maximum has been reached.
36 = Balance does not exceed copayment amount.
37 = Balance does not exceed deductible amount.
38 = Services not provided or authorized by designated (network) providers.
39 = Services denied at the time authorization/pre-certification was requested.
40 = Charges do not meet qualifications for emergency/urgent care.
41 = Discount agreed to in Preferred Provider contract.
42 = Charges exceed our fee schedule or maximum allowable amount.
43 = Gramm-Rudman reduction.
44 = Prompt-pay discount.
45 = Charges exceed your contracted/legislated fee arrangement.
46 = This (these) service(s) is(are) not covered.
47 = This (these) diagnosis(es) is(are) not covered,

1 REV_CNTR_ANSI_TB — Revenue Center ANSI Code Table

missing, or are invalid.
48 = This (these) procedure(s) is(are) not covered.
49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.

1 REV_CNTR_ANSI_TB — Revenue Center ANSI Code Table

51 = These are non-covered services because this a pre-existing condition.
52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
53 = Services by an immediate relative or a member of the same household are not covered.
54 = Multiple physicians/assistants are not covered in this case.
55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.
57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
60 = Charges for outpatient services with the proximity to inpatient services are not covered.
61 = Charges adjusted as penalty for failure to obtain second surgical opinion.
62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.
63 = Correction to a prior claim. INACTIVE
64 = Denial reversed per Medical Review. INACTIVE
65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE
66 = Blood Deductible.
67 = Lifetime reserve days. INACTIVE
68 = DRG weight. INACTIVE
69 = Day outlier amount.
70 = Cost outlier amount.
71 = Primary Payer amount.
72 = Coinsurance day. INACTIVE
73 = Administrative days. INACTIVE
74 = Indirect Medical Education Adjustment.
75 = Direct Medical Education Adjustment.
76 = Disproportionate Share Adjustment.
77 = Covered days. INACTIVE
78 = Non-covered days/room charge adjustment.
79 = Cost report days. INACTIVE
80 = Outlier days. INACTIVE
81 = Discharges. INACTIVE

82 = PIP days. INACTIVE
83 = Total visits. INACTIVE
84 = Capital adjustments. INACTIVE
85 = Interest amount. INACTIVE
86 = Statutory adjustment. INACTIVE
87 = Transfer amounts.
88 = Adjustment amount represents collection against
receivable created in prior overpayment.
89 = Professional fees removed from charges.
90 = Ingredient cost adjustment.

1 REV_CNTR_ANSI_TB Revenue Center ANSI Code Table

91 = Dispensing fee adjustment.
92 = Claim paid in full. INACTIVE
93 = No claim level adjustment. INACTIVE
94 = Process in excess of charges.
95 = Benefits adjusted. Plan procedures not followed.
96 = Non-covered charges.
97 = Payment is included in allowance for another
service/procedure.
98 = The hospital must file the Medicare claim for this
inpatient non-physician service. INACTIVE
99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
100 = Payment made to patient/insured/responsible party.
101 = Predetermination: anticipated payment upon comple-
tion of services or claim ajudication.
102 = Major medical adjustment.
103 = Provider promotional discount (i.e. Senior citizen
discount).
104 = Managed care withholding.
105 = Tax withholding.
106 = Patient payment option/election not in effect.
107 = Claim/service denied because the related or qualifying
claim/service was not paid or identified on the claim.
108 = Claim/service reduced because rent/purchase guidelines
were not met.
109 = Claim not covered by this payer/contractor. You must
send the claim to the correct payer/contractor.
110 = Billing date predates service date.
111 = Not covered unless the provider accepts assignment.
112 = Claim/service adjusted as not furnished directly
to the patient and/or not documented.
113 = Claim denied because service/procedure was provided
outside the United States or as a result of war.
114 = Procedure/product not approved by the Food and Drug
Administration.
115 = Claim/service adjusted as procedure postponed or
canceled.
116 = Claim/service denied. The advance indemnification
notice signed by the patient did not comply with
requirements.
117 = Claim/service adjusted because transportation is only
covered to the closest facility that can provide
the necessary care.
118 = Charges reduced for ESRD network support.
119 = Benefit maximum for this time period has been reached.
120 = Patient is covered by a managed care plan. INACTIVE

121 = Indemnification adjustment.
122 = Psychiatric reduction.
123 = Payer refund due to overpayment. INACTIVE
124 = Payer refund amount - not our patient. INACTIVE
125 = Claim/service adjusted due to a submission/billing error(s).
126 = Deductible - Major Medical.
127 = Coinsurance - Major Medical.
128 = Newborn's services are covered in the mother's allowance.
129 = Claim denied - prior processing information appears incorrect.
130 = Paper claim submission fee.

1 REV_CNTR_ANSI_TB — Revenue Center ANSI Code Table

131 = Claim specific negotiated discount.
132 = Prearranged demonstration project adjustment.
133 = The disposition of this claim/service is pending further review.
134 = Technical fees removed from charges.
135 = Claim denied. Interim bills cannot be processed.
136 = Claim adjusted. Plan procedures of a prior payer were not followed.
137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138 = Claim/service denied. Appeal procedures not followed or time limits not met.
139 = Contracted funding agreement - subscriber is employed by the provider of services.
140 = Patient/Insured health identification number and name do not match.
141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.
142 = Claim adjusted by the monthly Medicaid patient liability amount.
A0 = Patient refund amount
A1 = Claim denied charges.
A2 = Contractual adjustment.
A3 = Medicare Secondary Payer liability met. INACTIVE
A4 = Medicare Claim PPS Capital Day Outlier Amount.
A5 = Medicare Claim PPS Capital Cost Outlier Amount.
A6 = Prior hospitalization or 30 day transfer requirement not met.
A7 = Presumptive Payment Adjustment.
A8 = Claim denied; ungroupable DRG.
B1 = Non-covered visits.
B2 = Covered visits. INACTIVE
B3 = Covered charges. INACTIVE
B4 = Late filing penalty.
B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.
B6 = This service/procedure is adjusted when performed/ billed by this type of provider, by this type of facility, or by a provider of this specialty.
B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.

B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.
B9 = Services not covered because the patient is enrolled in a Hospice.
B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12 = Services not documented in patients' medical records.
B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.

1 REV_CNTR_ANSI_TB — Revenue Center ANSI Code Table

B14 = Claim/service denied because only one visit or consultation per physician per day is covered.
B15 = Claim/service adjusted because this procedure/service is not paid separately.
B16 = Claim/service adjusted because 'New Patient' qualifications were not met.
B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.
B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE
B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.
B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE
B22 = This claim/service is adjusted based on the diagnosis.
B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.
W1 = Workers Compensation State Fee Schedule Adjustment.

1 REV_CNTR_APC_TB — Revenue Center Ambulatory Payment Classification (APC)

0001 = Photochemotherapy
0002 = Fine needle Biopsy/Aspiration
0003 = Bone Marrow Biopsy/Aspiration
0004 = Level I Needle Biopsy/ Aspiration Except Bone Marrow
0005 = Level II Needle Biopsy /Aspiration Except Bone Marrow
0006 = Level I Incision & Drainage
0007 = Level II Incision & Drainage

0008 = Level III Incision & Drainage
0009 = Nail Procedures
0010 = Level I Destruction of Lesion
0011 = Level II Destruction of Lesion
0012 = Level I Debridement & Destruction
0013 = Level II Debridement & Destruction
0014 = Level III Debridement & Destruction
0015 = Level IV Debridement & Destruction
0016 = Level V Debridement & Destruction
0017 = Level VI Debridement & Destruction
0018 = Biopsy Skin, Subcutaneous Tissue or Mucous Membrane
0019 = Level I Excision/ Biopsy
0020 = Level II Excision/ Biopsy
0021 = Level III Excision/ Biopsy
0022 = Level IV Excision/ Biopsy
0023 = Exploration Penetrating Wound
0024 = Level I Skin Repair
0025 = Level II Skin Repair
0026 = Level III Skin Repair
0027 = Level IV Skin Repair
0029 = Incision/Excision Breast
0030 = Breast Reconstruction/Mastectomy
0031 = Hyperbaric Oxygen
0032 = Placement Transvenous Catheters/Arterial Cutdown
0033 = Partial Hospitalization
0040 = Arthrocentesis & Ligament/Tendon Injection
0041 = Arthroscopy
0042 = Arthroscopically-Aided Procedures
0043 = Closed Treatment Fracture Finger/Toe/Trunk
0044 = Closed Treatment Fracture/Dislocation Except Finger/Toe/Trunk
0045 = Bone/Joint Manipulation Under Anesthesia
0046 = Open/Percutaneous Treatment Fracture or Dislocation
0047 = Arthroplasty without Prosthesis
0048 = Arthroplasty with Prosthesis
0049 = Level I Musculoskeletal Procedures Except Hand and Foot
0050 = Level II Musculoskeletal Procedures Except Hand and Foot
0051 = Level III Musculoskeletal Procedures Except Hand and Foot
0052 = Level IV Musculoskeletal Procedures Except Hand and Foot
0053 = Level I Hand Musculoskeletal Procedures
0054 = Level II Hand Musculoskeletal Procedures
0055 = Level I Foot Musculoskeletal Procedures
0056 = Level II Foot Musculoskeletal Procedures
0057 = Bunion Procedures

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)
	---	---

0058 = Level I Strapping and Cast Application
0059 = Level II Strapping and Cast Application
0060 = Manipulation Therapy
0070 = Thoracentesis/Lavage Procedures
0071 = Level I Endoscopy Upper Airway
0072 = Level II Endoscopy Upper Airway
0073 = Level III Endoscopy Upper Airway

0074 = Level IV Endoscopy Upper Airway
0075 = Level V Endoscopy Upper Airway
0076 = Endoscopy Lower Airway
0077 = Level I Pulmonary Treatment
0078 = Level II Pulmonary Treatment
0079 = Ventilation Initiation and Management
0080 = Diagnostic Cardiac Catheterization
0081 = Non-Coronary Angioplasty or Atherectomy
0082 = Coronary Atherectomy
0083 = Coronary Angiosplasty
0084 = Level I Electrophysiologic Evaluation
0085 = Level II Electrophysiologic Evaluation
0086 = Ablate Heart Dysrhythm Focus
0087 = Cardiac Electrophysiologic Recording/Mapping
0088 = Thrombectomy
0089 = Level I Implantation/Removal/Revision of Pacemaker,
AICD Vascular Device
0090 = Level II Implantation/Removal/Revision of Pacemaker,
AICD Vascular Device
0091 = Level I Vascular Ligation
0092 = Level II Vascular Ligation
0093 = Vascular Repair/Fistula Construction
0094 = Resuscitation and Cardioversion
0095 = Cardiac Rehabilitation
0096 = Non-Invasive Vascular Studies
0097 = Cardiovascular Stress Test
0098 = Injection of Sclerosing Solution
0099 = Continuous Cardiac Monitoring
0100 = Continuous ECG
0101 = Tilt Table Evaluation
0102 = Electronic Analysis of Pacemakers/other Devices
0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell
Transplant
0110 = Transfusion
0111 = Blood Product Exchange
0112 = Extracorporeal Photopheresis
0113 = Excision Lymphatic System
0114 = Thyroid/Lymphadenectomy Procedures
0116 = Chemotherapy Administration by Other Technique
Except Infusion
0117 = Chemotherapy Administration by Infusion Only
0118 = Chemotherapy Administration by Both Infusion and
Other Technique
0120 = Infusion Therapy Except Chemotherapy
0121 = Level I Tube changes and Repositioning
0122 = Level II Tube changes and Repositioning
0123 = Level III Tube changes and Repositioning
0130 = Level I Laparoscopy
0131 = Level II Laparoscopy
0132 = Level III Laparoscopy
0140 = Esophageal Dilation without Endoscopy

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)
	---	---

0141 = Upper GI Procedures
0142 = Small Intestine Endoscopy
0143 = Lower GI Endoscopy
0144 = Diagnostic Anoscopy

0145 = Therapeutic Anoscopy
0146 = Level I Sigmoidoscopy
0147 = Level II Sigmoidoscopy
0148 = Level I Anal/Rectal Procedure
0149 = Level II Anal/Rectal Procedure
0150 = Level III Anal/Rectal Procedure
0151 = Endoscopic Retrograde Cholangio-Pancreatography (ERCP)
0152 = Percutaneous Biliary Endoscopic Procedures
0153 = Peritoneal and Abdominal Procedures
0154 = Hernia/Hydrocele Procedures
0157 = Colorectal Cancer Screening: Barium Enema
(Not subject to National coinsurance)
0158 = Colorectal Cancer Screening: Colonoscopy
Not subject to National coinsurance. Minimum
unadjusted coinsurance is 25% of the payment rate.
Payment rate is lower of the HOPD payment rate or
the Ambulatory Surgical Center payment.
0159 = Colorectal Cancer Screening: Flexible Sigmoidoscopy
Not subject to National coinsurance. Minimum
unadjusted coinsurance is 25% of the payment rate.
Payment rate is lower of the HOPD payment rate or
the Ambulatory Surgical Center payment.
0160 = Level I Cystourethroscopy and other Genitourinary
Procedures
0161 = Level II Cystourethroscopy and other Genitourinary
Procedures
0162 = Level III Cystourethroscopy and other Genitourinary
Procedures
0163 = Level IV Cystourethroscopy and other Genitourinary
Procedures
0164 = Level I Urinary and Anal Procedures
0165 = Level II Urinary and Anal Procedures
0166 = Level I Urethral Procedures
0167 = Level II Urethral Procedures
0168 = Level III Urethral Procedures
0169 = Lithotripsy
0170 = Dialysis for Other Than ESRD Patients
0180 = Circumcision
0181 = Penile Procedures
0182 = Insertion of Penile Prosthesis
0183 = Testes/Epididymis Procedures
0184 = Prostate Biopsy
0190 = Surgical Hysteroscopy
0191 = Level I Female Reproductive Procedures
0192 = Level II Female Reproductive Procedures
0193 = Level III Female Reproductive Procedures
0194 = Level IV Female Reproductive Procedures
0195 = Level V Female Reproductive Procedures
0196 = Dilatation & Curettage
0197 = Infertility Procedures
0198 = Pregnancy and Neonatal Care Procedures
0199 = Vaginal Delivery
0200 = Therapeutic Abortion
0201 = Spontaneous Abortion

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)
	---	---

0210 = Spinal Tap

0211 = Level I Nervous System Injections
0212 = Level II Nervous System Injections
0213 = Extended EEG Studies and Sleep Studies
0214 = Electroencephalogram
0215 = Level I Nerve and Muscle Tests
0216 = Level II Nerve and Muscle Tests
0217 = Level III Nerve and Muscle Tests
0220 = Level I Nerve Procedures
0221 = Level II Nerve Procedures
0222 = Implantation of Neurological Device
0223 = Level I Revision/Removal Neurological Device
0224 = Level II Revision/Removal Neurological Device
0225 = Implantation of Neurostimulator Electrodes
0230 = Level I Eye Tests
0231 = Level II Eye Tests
0232 = Level I Anterior Segment Eye
0233 = Level II Anterior Segment Eye
0234 = Level III Anterior Segment Eye Procedures
0235 = Level I Posterior Segment Eye Procedures
0236 = Level II Posterior Segment Eye Procedures
0237 = Level III Posterior Segment Eye Procedures
0238 = Level I Repair and Plastic Eye Procedures
0239 = Level II Repair and Plastic Eye Procedures
0240 = Level III Repair and Plastic Eye Procedures
0241 = Level IV Repair and Plastic Eye Procedures
0242 = Level V Repair and Plastic Eye Procedures
0243 = Strabismus/Muscle Procedures
0244 = Corneal Transplant
0245 = Cataract Procedures without IOL Insert
0246 = Cataract Procedures with IOL Insert
0247 = Laser Eye Procedures Except Retinal
0248 = Laser Retinal Procedures
0250 = Nasal Cauterization/Packing
0251 = Level I ENT Procedures
0252 = Level II ENT Procedures
0253 = Level III ENT Procedures
0254 = Level IV ENT Procedures
0256 = Level V ENT Procedures
0257 = Implantation of Cochlear Device
0258 = Tonsil and Adenoid Procedures
0260 = Level I Plain Film Except Teeth
0261 = Level II Plain Film Except Teeth Including Bone
Density Measurement
0262 = Plain Film of Teeth
0263 = Level I Miscellaneous Radiology Procedures
0264 = Level II Miscellaneous Radiology Procedures
0265 = Level I Diagnostic Ultrasound Except Vascular
0266 = Level II Diagnostic Ultrasound Except Vascular
0267 = Vascular Ultrasound
0268 = Guidance Under Ultrasound
0269 = Echocardiogram Except Transesophageal
0270 = Transesophageal Echocardiogram
0271 = Mammography
0272 = Level I Fluoroscopy
0273 = Level II Fluoroscopy
0274 = Myelography
0275 = Arthrography

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)

0276 = Level I Digestive Radiology
0277 = Level II Digestive Radiology
0278 = Diagnostic Urography
0279 = Level I Diagnostic Angiography and Venography Except Extremity
0280 = Level II Diagnostic Angiography and Venography Except Extremity
0281 = Venography of Extremity
0282 = Level I Computerized Axial Tomography
0283 = Level II Computerized Axial Tomography
0284 = Magnetic Resonance Imaging
0285 = Positron Emission Tomography (PET)
0286 = Myocardial Scans
0290 = Standard Non-Imaging Nuclear Medicine
0291 = Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans
0292 = Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans
0294 = Level I Therapeutic Nuclear Medicine
0295 = Level II Therapeutic Nuclear Medicine
0296 = Level I Therapeutic Radiologic Procedures
0297 = Level II Therapeutic Radiologic Procedures
0300 = Level I Radiation Therapy
0301 = Level II Radiation Therapy
0302 = Level III Radiation Therapy
0303 = Treatment Device Construction
0304 = Level I Therapeutic Radiation Treatment Preparation
0305 = Level II Therapeutic Radiation Treatment Preparation
0310 = Level III Therapeutic Radiation Treatment Preparation
0311 = Radiation Physics Services
0312 = Radioelement Applications
0313 = Brachytherapy
0314 = Hyperthermic Therapies
0320 = Electroconvulsive Therapy
0321 = Biofeedback and Other Training
0322 = Brief Individual Psychotherapy
0323 = Extended Individual Psychotherapy
0324 = Family Psychotherapy
0325 = Group Psychotherapy
0330 = Dental Procedures
0340 = Minor Ancillary Procedures
0341 = Immunology Tests
0342 = Level I Pathology
0343 = Level II Pathology
0344 = Level III Pathology
0354 = Administration of Influenza Vaccine (Not subject to national coinsurance)
0355 = Level I Immunizations
0356 = Level II Immunizations
0357 = Level III Immunizations
0358 = Level IV Immunizations
0359 = Injections
0360 = Level I Alimentary Tests

		0361 = Level II Alimentary Tests	
		0362 = Fitting of Vision Aids	
1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)	
		0363 = Otorhinolaryngologic Function Tests	
		0364 = Level I Audiometry	
		0365 = Level II Audiometry	
		0366 = Electrocardiogram (ECG)	
		0367 = Level I Pulmonary Test	
		0368 = Level II Pulmonary Test	
		0369 = Level III Pulmonary Test	
		0370 = Allergy Tests	
		0371 = Allergy Injections	
		0372 = Therapeutic Phlebotomy	
		0373 = Neuropsychological Testing	
		0374 = Monitoring Psychiatric Drugs	
		0600 = Low Level Clinic Visits	
		0601 = Mid Level Clinic Visits	
		0602 = High Level Clinic Visits	
		0603 = Interdisciplinary Team Conference	
		0610 = Low Level Emergency Visits	
		0611 = Mid Level Emergency Visits	
		0612 = High Level Emergency Visits	
		0620 = Critical Care	
		0701 = Strontium (eligible for pass-through payments)	
		0702 = Samariam (eligible for pass-through payments)	
		0704 = Satumomab Pendetide (eligible for pass-through payments)	
		0705 = Tc99 Tetrofosmin (eligible for pass-through payments)	
		0725 = Leucovorin Calcium (eligible for pass-through payments)	
		0726 = Dexrazoxane Hydrochloride (eligible for pass-) through payments)	
		0727 = Injection, Etidronate Disodium (eligible for pass-through payments)	
		0728 = Filgrastim (G-CSF) (eligible for pass-through payments)	
		0730 = Pamidronate Disodium (eligible for pass-through payments)	
		0731 = Sargramostim (GM-CSF) (eligible for pass-through payments)	
		0732 = Mesna (eligible for pass-through payments)	
		0733 = Epoetin Alpha (eligible for pass-through) payments)	
		0750 = Dolasetron Mesylate 10 mg (eligible for pass-through payments)	
		0754 = Metoclopramide HCL (eligible for pass-through payments)	
		0755 = Thiethylperazine Maleate (eligible for pass-through payments)	
		0761 = Oral Substitute for IV Antiemtic (eligible for pass-through payments)	
		0762 = Dronabinol (elibible for pass-through payments)	
		0763 = Dolasetron Mesylate 100 mg Oral (eligible for pass-through payments)	
		0764 = Granisetron HCL, 100 mcg (eligible for pass-	

			through payments) 0765 = Granisetron HCL, 1mg Oral (eligible for pass-through payments) 0768 = Ondansetron Hydrochloride per 1 mg Injection (eligible for pass-through payments)
1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)	
	---	---	
			0769 = Ondansetron Hydrochloride 8 mg oral (eligible for pass-through payments) 0800 = Leuprolide Acetate per 3.75 mg (eligible for pass-through payments) 0801 = Cyclophosphamide (eligible for pass-through payments) 0802 = Etoposide (eligible for pass-through payments) 0803 = Melphalan (eligible for pass-through payments) 0807 = Aldesleukin single use vial (eligible for pass-through payments) 0809 = BCG (Intravesical) one vial (eligible for pass-through payments) 0810 = Goserelin Acetate Implant, per 3.6 mg (eligible for pass-through payments) 0811 = Carboplatin 50 mg (eligible for pass-through payments) 0812 = Carmustine 100 mg (eligible for pass-through payments) 0813 = Cisplatin 10 mg (eligible for pass-through payments) 0814 = Asparaginase, 10,000 units (eligible for pass-through payments) 0815 = Cyclophosphamide 100 mg (eligible for pass-through payments) 0816 = Cyclophosphamide, Lyophilized 100 mg (eligible for pass-through payments) 0817 = Cytrabine 100 mg (eligible for pass-through payments) 0818 = Dactinomycin 0.5 mg (eligible for pass-through payments) 0819 = Dacarbazine 100 mg (eligible for pass-through payments) 0820 = Daunorubicin HCI 10 mg (eligible for pass-through payments) 0821 = Daunorubicin Citrate, Liposomal Formulation, 10 mg (eligible for pass-through payments) 0822 = Diethylstibestrol Diphosphate 250 mg (eligible for pass-through payments) 0823 = Docetaxel 20 mg (eligible for pass-through payments) 0824 = Etoposide 10 mg (eligible for pass-through payments) 0826 = Methotrexate Oral 2.5 mg (eligible for pass-through payments) 0827 = Floxuridine 500 mg (eligible for pass-through payments) 0828 = Gemcitabine HCL 200 mg (eligibile for pass-through payments) 0830 = Irinotecan 20 mg (eligible for pass-through payments)

			0831 = Ifosfamide per 1 gram (eligible for pass-through payments) 0832 = Idarubicin Hydrochloride 5 mg (eligible for pass-through payments) 0833 = Interferon Alfacon-1, Recombinant, 1 mcg (eligible for pass-through payments) 0834 = Interferon, Alfa-2A, Recombinant 3 million units (eligible for pass-through payments)
1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)	
	---	---	
			0836 = Interferon, Alfa-2B, Recombinant, 1 million units (eligible for pass-through payments) 0838 = Interferon, Gamma 1-B, 3 million units (eligible for pass-through payments) 0839 = Mechlorethamine HCI 10 mg (eligible for pass-through payments) 0840 = Melphalan HCI 50 mg (eligible for pass-through payments) 0841 = Methotrexate Sodium 5 mg (eligible for pass-through payments) 0842 = Fludarabine Phosphate 50 mg (eligible for pass-through payments) 0843 = Pegaspargase per single dose vial (eligible for pass-through payments) 0844 = Pentostatin 10 mg (eligible for pass-through payments) 0847 = Doxorubicin HCL 10 mg (eligible for pass-through payments) 0849 = Rituximab, 100 mg (eligible for pass-through payments) 0850 = Streptozocin 1 gm (eligible for pass-through payments) 0851 = Thiotepa 15 mg (eligible for pass-through payments) 0852 = Topotecan 4 mg (eligible for pass-through payments) 0853 = Vinblastine Sulfate 1 mg (eligible for pass-through payments) 0854 = Vincristine Sulfate 1 mg (eligible for pass-through payments) 0855 = Vinorelbine Tartrate per 10 mg (eligible for pass-through payments) 0856 = Porfimer Sodium 75 mg (eligible for pass-through payments) 0857 = Bleomycin Sulfate 15 units (eligible for pass-through payments) 0858 = Cladribine, 1mg (eligible for pass-through payments) 0859 = Fluorouracil (eligible for pass-through payments) 0860 = Plicamycin 2.5 mg (eligible for pass-through payments) 0861 = Leuprolide Acetate 1 mg (eligible for pass-through payments) 0862 = Mitomycin, 5mg (eligible for pass-through payments) 0863 = Paclitaxel, 30mg (eligible for pass-through payments) 0864 = Mitoxantrone HCl, per 5mg (eligible for pass-through payments) 0865 = Interferon alfa-N3, 250,000 IU (eligible for pass-through payments) 0884 = Rho (D) Immune Globulin, Human one dose pack

			(eligible for pass-through payments) 0886 = Azathioprine, 50 mg oral (Not subject to national coinsurance) 0887 = Azathioprine, Parenteral 100 mg, 20 ml each injection (Not subject to national coinsurance) 0888 = Cyclosporine, Oral 100 mg (Not subject to national coinsurance) 0889 = Cyclosporine, Parenteral (Not subject to national coinsurance) 0890 = Lymphocyte Immune Globulin 50 mg/ ml, 5 ml each (Not subject to national coinsurance)
1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)	

0891 = Tacrolimus per 1 mg oral
(Not subject to national coinsurance)
0892 = Daclizumab, Parenteral, 25 mg
(eligible for pass-through payments)
0900 = Injection, Alglucerase per 10 units
(eligible for pass-through payments)
0901 = Alpha I, Proteinase Inhibitor, Human per 10mg
(eligible for pass-through payments)
0902 = Botulinum Toxin, Type A per unit
(eligible for pass-through payments)
0903 = CMV Immune Globulin
(eligible for pass-through payments)
0905 = Immune Globulin per 500 mg
(eligible for pass-through payments)
0906 = RSV Immune Globulin
(eligible for pass-through payments)
0907 = Ganciclovir Sodium 500 mg injection
(Not subject to national coinsurance)
0908 = Tetanus Immune Globulin, Human, up to 250 units
(Not subject to national coinsurance)
0909 = Interferon Beta - 1a 33 mcg (eligible for pass-through payments)
0910 = Interferon Beta - 1b 0.25 mg (eligible for pass-through payments)
0911 = Streptokinase per 250,000 iu
(Not subject to national coinsurance)
0913 = Ganciclovir 4.5 mg, Implant (eligible for pass-through payments)
0914 = Reteplase, 37.6 mg (Two Single Use Vials)
(Not subject to national coinsurance)
0915 = Alteplase recombinant, 10mg
(Not subject to national coinsurance)
0916 = Imiglucerase per unit (eligible for pass-through payments)
0917 = Dipyridamole, 10mg / Adenosine 6MG
(Not subject to national coinsurance)
0918 = Brachytherapy Seeds, Any type, Each (eligible for pass-through payments)
0925 = Factor VIII (Antihemophilic Factor, Human) per iu (eligible for pass-through payments)
0926 = Factor VIII (Antihemophilic Factor, Porcine) per iu (eligible for pass-through payments)
0927 = Factor VIII (Antihemophilic Factor, Recombinant) per iu (eligible for pass-through payments)

0928 = Factor IX, Complex (eligible for pass-through payments)
0929 = Other Hemophilia Clotting Factors per iu (eligible for pass-through payments)
0930 = Antithrombin III (Human) per iu (eligible for pass-through payments)
0931 = Factor IX (Antihemophilic Factor, Purified, Non-Recombinant) (eligible for pass-through payments)
0932 = Factor IX (Antihemophilic Factor, Recombinant) (eligible for pass-through payments)
0949 = Plasma, Pooled Multiple Donor, Solvent/Detergent Treated, Frozen (not subject to national coinsurance)
0950 = Blood (Whole) For Transfusion (not subject to national coinsurance)

1 REV_CNTR_APC_TB — Revenue Center Ambulatory Payment Classification (APC)

0952 = Cryoprecipitate (not subject to national coinsurance)
0953 = Fibrinogen Unit (not subject to national coinsurance)
0954 = Leukocyte Poor Blood (not subject to national coinsurance)
0955 = Plasma, Fresh Frozen (not subject to national coinsurance)
0956 = Plasma Protein Fraction (not subject to national coinsurance)
0957 = Platelet Concentrate (not subject to national coinsurance)
0958 = Platelet Rich Plasma (not subject to national coinsurance)
0959 = Red Blood Cells (not subject to national coinsurance)
0960 = Washed Red Blood Cells (not subject to national coinsurance)
0961 = Infusion, Albumin (Human) 5%, 500 ml (not subject to national coinsurance)
0962 = Infusion, Albumin (Human) 25%, 50 ml (not subject to national coinsurance)
0970 = New Technology - Level I ($0 - $50) (not subject to national coinsurance)
0971 = New Technology - Level II ($50 - $100) (not subject to national coinsurance)
0972 = New Technology - Level III ($100 - $200) (not subject to national coinsurance)
0973 = New Technology - Level IV ($200 - $300) (not subject to national coinsurance)
0974 = New Technology - Level V ($300 - $500) (not subject to national coinsurance)
0975 = New Technology - Level VI ($500 - $750) (not subject to national coinsurance)
0976 = New Technology - Level VII ($750 - $1000) (not subject to national coinsurance)
0977 = New Technology - Level VIII ($1000 - $1250) (not subject to national coinsurance)
0978 = New Technology - Level IX ($1250 - $1500) (not subject to national coinsurance)
0979 = New Technology - Level X ($1500 - $1750) (not subject to national coinsurance)
0980 = New Technology - Level XI ($1750 - $2000) (not subject to national coinsurance)

			0981 = New Technology - Level XII ($2000 - $2500) (not subject to national coinsurance) 0982 = New Technology - Level XIII ($2500 - $3500) (not subject to national coinsurance) 0983 = New Technology - Level XIV ($3500 - $5000) (not subject to national coinsurance) 0984 = New Technology - Level XV ($5000 - $6000) (not subject to national coinsurance) 7000 = Amifostine, 500 mg (eligible for pass-through payments) 7001 = Amphotericin B lipid complex, 50 mg, Inj (eligible for pass-through payments) 7002 = Clonidine, HCl, 1 MG (eligible for pass-through payments) 7003 = Epoprostenol, 0.5 MG, inj (eligible for pass-through payments) 7004 = Immune globulin intravenous human 5g, inj
1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)	(eligible for pass-through payments) 7005 = Gonadorelin hcI, 100 mcg (eligible for pass-through payments) 7007 = Milrinone lacetate, per 5 ml, inj (not subject to national coinsurance) 7010 = Morphine sulfate concentrate (preservative free) per 10 mg (eligible for pass-through payments) 7011 = Oprelevekin, inj, 5 mg (eligible for pass-through payments) 7012 = Pentamidine isethionate, 300 mg (eligible for pass-through payments) 7014 = Fentanyl citrate, inj, up to 2 ml (eligible for pass-through payments) 7015 = Busulfan, oral 2 mg (eligible for pass-through payments) 7019 = Aprotinin, 10,000 kiu (eligible for pass-through payments) 7021 = Baclofen, intrathecal, 50 mcg (eligible for pass-through payments) 7022 = Elliotts B Solution, per ml (eligible for pass-through payments) 7023 = Treatment for bladder calculi, I.e. Renacidin per 500 ml (eligible for pass-through payments) 7024 = Corticorelin ovine triflutate, 0.1 mg (eligible for pass-through payments) 7025 = Digoxin immune FAB (Ovine), 10 mg (eligible for pass-through payments) 7026 = Ethanolamine oleate, 1000 ml (eligible for pass-through payments) 7027 = Fomepizole, 1.5 G (eligible for pass-through payments) 7028 = Fosphenytoin, 50 mg (eligible for pass-through payments) 7029 = Glatiramer acetate, 25 mg (eligible for pass-through payments) 7030 = Hemin, 1 mg (eligible for pass-through payments) 7031 = Octreotide Acetate, 500 mcg

(eligible for pass-through payments)
7032 = Sermorelin acetate, 0.5 mg
(eligible for pass-through payments)
7033 = Somatrem, 5 mg
(eligible for pass-through payments)
7034 = Somatropin, 1 mg
(eligible for pass-through payments)
7035 = Teniposide, 50 mg
(eligible for pass-through payments)
7036 = Urokinase, inj, IV, 250,000 I.U.
(not subject to national coinsurance)
7037 = Urofollitropin, 75 I.U.
(eligible for pass-through payments)
7038 = Muromonab-CD3, 5 mg
(eligible for pass-through payments)
7039 = Pegademase bovine inj 25 I.U.
(eligible for pass-through payments)
7040 = Pentastarch 10% inj, 100 ml
(eligible for pass-through payments)
7041 = Tirofiban HCL, 0.5 mg

1 REV_CNTR_APC_TB — Revenue Center Ambulatory Payment Classification (APC)

(not subject to national coinsurance)
7042 = Capecitabine, oral 150 mg
(eligible for pass-through payments)
7043 = Infliximab, 10 MG (eligible for pass-through payments)
7045 = Trimetrexate Glucoronate (eligible for pass-through payments)
7046 = Doxorubicin Hcl Liposome (eligible for pass-through payments)

1 REV_CNTR_DDCTBL_COINSRNC_TB — Revenue Center Deductible Coinsurance Code

0 = Charges are subject to deductible and coinsurance
1 = Charges are not subject to deductible
2 = Charges are not subject to coinsurance
3 = Charges are not subject to deductible or coinsurance
4 = No charge or units associated with this revenue center code. (For multiple HCPCS per single revenue center code)

For revenue center code 0001, the following MSP override values may be present:

M = Override code; EGHP services involved (eff 12/90 for non-institutional claims; 10/93 for institutional claims)
N = Override code; non-EGHP services involved (eff 12/90 for non-institutional claims; 10/93 for institutional claims)
X = Override code: MSP cost avoided (eff 12/90 for non-institutional claims;

10/93 for institutional claims)

1 REV_CNTR_PMT_MTHD_IND_TB — Revenue Center Payment Method Indicator Table

**********Service Indicator**********
********** 1st position **********
A = Services not paid under OPPS
C = Inpatient procedure
E = Noncovered items or services
F = Corneal issue acquistion
G = Current drug or biological pass-through
H = Device pass-through
J = New drug or new biological pass-through
N = Packaged incidental service
P = Partial hospitalization services
S = Significant procedure not subject to multiple procedure discounting
T = Significant procedure subject to multiple procedure discounting
V = Medical visit to clinic or emergency department
X = Ancillary service

**********Payment Indicator**********
********** 2nd position **********
1 = Paid standard hospital OPPS amount (service indicators S,T,V,X)
2 = Services not paid under OPPS (service indicator A, or no HCPCS code and not certain revenue center codes)
3 = Not paid (service indicators C & E)
4 = Acquisition cost paid (service indicator F)
5 = Additional payment for current drug or biological (service indicator G)
6 = Additional payment for device (service indicator H)
7 = Additional payment for new drug or new biological (service indicator J)
8 = Paid partial hospitalization per diem (service indicator P)
9 = No additional payment, payment included in line items with APCs (service indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization training)

1 REV_CNTR_PRICNG_IND_TB — Revenue Center Pricing Indicator Table

A = A valid HCPCS code not subject to a fee schedule payment.

Reimbursement is calculated on provider submitted charges.

B = A valid HCPCS code subject to the fee schedule payment. Reimbursement is the lesser of provider submitted charges or the fee schedule amount.

D = a valid radiology HCPCS code subject to the Radiology Pricer and the rate is reflected as zeroes on the HCPCS file and cost report. The Radiology Pricer treates this HCPCS as a non-covered service. Reimbursement is calculated on provider submitted charges.

E = A valid ASC HCPCS code subject to the ASC Pricer. The rate is reflected as zeroes on the HCPCS file. The ASC Pricer determines the ASC payment rate and is reported on the cost report.

F = A valid ESRD HCPCS code subject to the parameter rate. Reimbursement is the lesser of provider submitted charges or the fee schedule amount for non-dialysis HCPCS. Reimbursement is calculated on the provider file rates for dialysis HCPCS.

G = A valid HCPCS, code is subject to a fee schedule, but the rate is no longer present on the HCPCS file. Reimbursement is calculated on provider submitted charges.

H = A valid DME HCPCS, code is subject to a fee schedule. The rates are reflected under the DME segment. Reimbursement is calculated either on a fee schedule, provider submitted charges or the lesser of provider submitted, or the fee schedule depending o the category.

I = A valid DME category 5 HCPCS, HCPCS is not found on the DME history record, but a match was found on HIC, category and generic code. Claim must be reviewed by Medical Review before payment can be calculated.

J = A valid DME HCPCS, no DME history is present, and a prescription is required before delivery. Claim must be reviewed by Medical Review.

K = A valid DME HCPCS, prescribed has been reviewed, and fee schedule payment is approved as prescription was present before delivery.

L = A valid TENS HCPCS, rental period is six months or greater and must be reviewed by Medical Review.

M = A valid TENS HCPCS, Medical Review has approved the rental charge in excess of five months.

R = A valid radiology HCPCS code and is subject to the Radiology Pricer. The rate is reported on the cost report. Reimbursement is calculated on provider submitted charges.

S = Valid influenza/PPV HCPCS. A fee amount is not applicable. The amount payable is present in the covered charge field. This amount is not subject to the coinsurance and deductible. This charge is subject to the provider's reimbursement rate.

T = Valid HCPCS. A fee amount is present. The amount payable should be the lower of the billed charge or

1 REV_CNTR_PRICNG_IND_TB — Revenue Center Pricing Indicator Table

fee amount. The system should compute the fee amount

by multiplying the covered units times the rate. The fee amount is not subject to coinsurance and deductible or provider's reimbursement rate.

1 REV_CNTR_TB — Revenue Center Table

0001 = Total charge
0022 = SNF claim paid under PPS submitted as TOB 21X, effective for cost reporting periods beginning on or after 7/1/98 (dates of service after 6/30/98). NOTE: This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.
0023 = Home Health services paid under PPS submitted as TOB 32X and 33X, effective 10/00. This code may appear multiple times on a claim to identify different HIPPS/Home Health Resource Groups (HRG).
0100 = All inclusive rate-room and board plus ancillary
0101 = All inclusive rate-room and board
0110 = Private medical or general-general classification
0111 = Private medical or general-medical/surgical/GYN
0112 = Private medical or general-OB
0113 = Private medical or general-pediatric
0114 = Private medical or general-psychiatric
0115 = Private medical or general-hospice
0116 = Private medical or general-detoxification
0117 = Private medical or general-oncology
0118 = Private medical or general-rehabilitation
0119 = Private medical or general-other
0120 = Semi-private 2 bed (medical or general) general classification
0121 = Semi-private 2 bed (medical or general) medical/surgical/GYN
0122 = Semi-private 2 bed (medical or general)-OB
0123 = Semi-private 2 bed (medical or general)-pediatric
0124 = Semi-private 2 bed (medical or general)-psychiatric
0125 = Semi-private 2 bed (medical or general)-hospice
0126 = Semi-private 2 bed (medical or general) detoxification
0127 = Semi-private 2 bed (medical or general)-oncology
0128 = Semi-private 2 bed (medical or general) rehabilitation
0129 = Semi-private 2 bed (medical or general)-other
0130 = Semi-private 3 and 4 beds-general classification
0131 = Semi-private 3 and 4 beds-medical/surgical/GYN
0132 = Semi-private 3 and 4 beds-OB
0133 = Semi-private 3 and 4 beds-pediatric
0134 = Semi-private 3 and 4 beds-psychiatric
0135 = Semi-private 3 and 4 beds-hospice
0136 = Semi-private 3 and 4 beds-detoxification
0137 = Semi-private 3 and 4 beds-oncology
0138 = Semi_private 3 and 4 beds-rehabilitation
0139 = Semi-private 3 and 4 beds-other
0140 = Private (deluxe)-general classification
0141 = Private (deluxe)-medical/surgical/GYN
0142 = Private (deluxe)-OB

0143 = Private (deluxe)-pediatric
0144 = Private (deluxe)-psychiatric
0145 = Private (deluxe)-hospice
0146 = Private (deluxe)-detoxification
0147 = Private (deluxe)-oncology
0148 = Private (deluxe)-rehabilitation
0149 = Private (deluxe)-other

1 REV_CNTR_TB Revenue Center Table
---------- --------------------

0150 = Room&Board ward (medical or general)
general classification
0151 = Room&Board ward (medical or general)
medical/surgical/GYN
0152 = Room&Board ward (medical or general)-OB
0153 = Room&Board ward (medical or general)-pediatric
0154 = Room&Board ward (medical or general)-psychiatric
0155 = Room&Board ward (medical or general)-hospice
0156 = Room&Board ward (medical or general)-detoxification
0157 = Room&Board ward (medical or general)-oncology
0158 = Room&Board ward (medical or general)-rehabilitation
0159 = Room&Board ward (medical or general)-other
0160 = Other Room&Board-general classification
0164 = Other Room&Board-sterile environment
0167 = Other Room&Board-self care
0169 = Other Room&Board-other
0170 = Nursery-general classification
0171 = Nursery-newborn
level I (routine)
0172 = Nursery-premature
newborn-level II (continuing care)
0173 = Nursery-newborn-level III (intermediate care)
(eff 10/96)
0174 = Nursery-newborn-level IV (intensive care)
(eff 10/96)
0175 = Nursery-neonatal ICU (obsolete eff 10/96)
0179 = Nursery-other
0180 = Leave of absence-general classification
0182 = Leave of absence-patient convenience charges
billable
0183 = Leave of absence-therapeutic leave
0184 = Leave of absence-ICF mentally retarded-any reason
0185 = Leave of absence-nursing home (hospitalization)
0189 = Leave of absence-other leave of absence
0190 = Subacute care - general classification
(eff. 10/97)
0191 = Subacute care - level I (eff. 10/97)
0192 = Subacute care - level II (eff. 10/97)
0193 = Subacute care - level III (eff. 10/97)
0194 = Subacute care - level IV (eff. 10/97)
0199 = Subacute care - other (eff 10/97)
0200 = Intensive care-general classification
0201 = Intensive care-surgical
0202 = Intensive care-medical
0203 = Intensive care-pediatric
0204 = Intensive care-psychiatric
0206 = Intensive care-post ICU; redefined as
intermediate ICU (eff 10/96)

0207 = Intensive care-burn care
0208 = Intensive care-trauma
0209 = Intensive care-other intensive care
0210 = Coronary care-general classification
0211 = Coronary care-myocardial infraction
0212 = Coronary care-pulmonary care
0213 = Coronary care-heart transplant
0214 = Coronary care-post CCU; redefined as
intermediate CCU (eff 10/96)
0219 = Coronary care-other coronary care

0220 = Special charges-general classification
0221 = Special charges-admission charge
0222 = Special charges-technical support charge
0223 = Special charges-UR service charge
0224 = Special charges-late discharge, medically
necessary
0229 = Special charges-other special charges
0230 = Incremental nursing charge rate-general
classification
0231 = Incremental nursing charge rate-nursery
0232 = Incremental nursing charge rate-OB
0233 = Incremental nursing charge rate-ICU (include
transitional care)
0234 = Incremental nursing charge rate-CCU (include
transitional care)
0235 = Incremental nursing charge rate-hospice
0239 = Incremental nursing charge rate-other
0240 = All inclusive ancillary-general classification
0241 = All inclusive ancillary-basic
0242 = All inclusive ancillary-comprehensive
0243 = All inclusive ancillary-specialty
0249 = All inclusive ancillary-other inclusive ancillary
0250 = Pharmacy-general classification
0251 = Pharmacy-generic drugs
0252 = Pharmacy-nongeneric drugs
0253 = Pharmacy-take home drugs
0254 = Pharmacy-drugs incident to other diagnostic service-
subject to payment limit
0255 = Pharmacy-drugs incident to radiology-
subject to payment limit
0256 = Pharmacy-experimental drugs
0257 = Pharmacy-non-prescription
0258 = Pharmacy-IV solutions
0259 = Pharmacy-other pharmacy
0260 = IV therapy-general classification
0261 = IV therapy-infusion pump
0262 = IV therapy-pharmacy services (eff 10/94)
0263 = IV therapy-drug supply/delivery (eff 10/94)
0264 = IV therapy-supplies (eff 10/94)
0269 = IV therapy-other IV therapy
0270 = Medical/surgical supplies-general classification
(also see 062X)
0271 = Medical/surgical supplies-nonsterile supply
0272 = Medical/surgical supplies-sterile supply
0273 = Medical/surgical supplies-take home supplies

0274 = Medical/surgical supplies-prosthetic/orthotic devices
0275 = Medical/surgical supplies-pace maker
0276 = Medical/surgical supplies-intraocular lens
0277 = Medical/surgical supplies-oxygen-take home
0278 = Medical/surgical supplies-other implants
0279 = Medical/surgical supplies-other devices
0280 = Oncology-general classification
0289 = Oncology-other oncology
0290 = DME (other than renal)-general classification
0291 = DME (other than renal)-rental
0292 = DME (other than renal)-purchase of new DME
0293 = DME (other than renal)-purchase of used DME
0294 = DME (other than renal)-related to and listed as DME
0299 = DME (other than renal)-other
0300 = Laboratory-general classification
0301 = Laboratory-chemistry
0302 = Laboratory-immunology
0303 = Laboratory-renal patient (home)
0304 = Laboratory-non-routine dialysis
0305 = Laboratory-hematology
0306 = Laboratory-bacteriology & microbiology
0307 = Laboratory-urology
0309 = Laboratory-other laboratory
0310 = Laboratory pathological-general classification
0311 = Laboratory pathological-cytology
0312 = Laboratory pathological-histology
0314 = Laboratory pathological-biopsy
0319 = Laboratory pathological-other
0320 = Radiology diagnostic-general classification
0321 = Radiology diagnostic-angiocardiography
0322 = Radiology diagnostic-arthrography
0323 = Radiology diagnostic-arteriography
0324 = Radiology diagnostic-chest X-ray
0329 = Radiology diagnostic-other
0330 = Radiology therapeutic-general classification
0331 = Radiology therapeutic-chemotherapy injected
0332 = Radiology therapeutic-chemotherapy oral
0333 = Radiology therapeutic-radiation therapy
0335 = Radiology therapeutic-chemotherapy IV
0339 = Radiology therapeutic-other
0340 = Nuclear medicine-general classification
0341 = Nuclear medicine-diagnostic
0342 = Nuclear medicine-therapeutic
0349 = Nuclear medicine-other
0350 = Computed tomographic (CT) scan-general classification
0351 = CT scan-head scan
0352 = CT scan-body scan
0359 = CT scan-other CT scans
0360 = Operating room services-general classification
0361 = Operating room services-minor surgery
0362 = Operating room services-organ transplant, other than kidney
0367 = Operating room services-kidney transplant

0369 = Operating room services-other operating room services
0370 = Anesthesia-general classification
0371 = Anesthesia-incident to RAD and subject to the payment limit
0372 = Anesthesia-incident to other diagnostic service and subject to the payment limit
0374 = Anesthesia-acupuncture
0379 = Anesthesia-other anesthesia
0380 = Blood-general classification
0381 = Blood-packed red cells
0382 = Blood-whole blood
0383 = Blood-plasma
0384 = Blood-platelets
0385 = Blood-leukocytes
0386 = Blood-other components
0387 = Blood-other derivatives (cryopricipatates)
0389 = Blood-other blood
0390 = Blood storage and processing-general classification
0391 = Blood storage and processing-blood administration
0399 = Blood storage and processing-other
0400 = Other imaging services-general classification
0401 = Other imaging services-diagnostic mammography
0402 = Other imaging services-ultrasound
0403 = Other imaging services-screening mammography (eff 1/1/91)
0404 = Other imaging services-positron emission tomography (eff 10/94)
0409 = Other imaging services-other
0410 = Respiratory services-general classification
0412 = Respiratory services-inhalation services
0413 = Respiratory services-hyperbaric oxygen therapy
0419 = Respiratory services-other
0420 = Physical therapy-general classification
0421 = Physical therapy-visit charge
0422 = Physical therapy-hourly charge
0423 = Physical therapy-group rate
0424 = Physical therapy-evaluation or re-evaluation
0429 = Physical therapy-other
0430 = Occupational therapy-general classification
0431 = Occupational therapy-visit charge
0432 = Occupational therapy-hourly charge
0433 = Occupational therapy-group rate
0434 = Occupational therapy-evaluation or re-evaluation
0439 = Occupational therapy-other (may include restorative therapy)
0440 = Speech language pathology-general classification
0441 = Speech language pathology-visit charge
0442 = Speech language pathology-hourly charge
0443 = Speech language pathology-group rate
0444 = Speech language pathology-evaluation or re-evaluation
0449 = Speech language pathology-other

0450 = Emergency room-general classification
0451 = Emergency room-emtala emergency medical screening
services (eff 10/96)
0452 = Emergency room-ER beyond emtala screening
(eff 10/96)
0456 = Emergency room-urgent care (eff 10/96)
0459 = Emergency room-other
0460 = Pulmonary function-general classification
0469 = Pulmonary function-other
0470 = Audiology-general classification
0471 = Audiology-diagnostic
0472 = Audiology-treatment
0479 = Audiology-other
0480 = Cardiology-general classification
0481 = Cardiology-cardiac cath lab
0482 = Cardiology-stress test
0483 = Cardiology-Echocardiology
0489 = Cardiology-other
0490 = Ambulatory surgical care-general classification
0499 = Ambulatory surgical care-other
0500 = Outpatient services-general classification
(deleted 9/93)
0509 = Outpatient services-other (deleted 9/93)
0510 = Clinic-general classification
0511 = Clinic-chronic pain center
0512 = Clinic-dental center
0513 = Clinic-psychiatric
0514 = Clinic-OB-GYN
0515 = Clinic-pediatric
0516 = Clinic-urgent care clinic (eff 10/96)
0517 = Clinic-family practice clinic (eff 10/96)
0519 = Clinic-other
0520 = Free-standing clinic-general classification
0521 = Free-standing clinic-rural health clinic
0522 = Free-standing clinic-rural health home
0523 = Free-standing clinic-family practice
0526 = Free-standing clinic-urgent care (eff 10/96)
0529 = Free-standing clinic-other
0530 = Osteopathic services-general classification
0531 = Osteopathic services-osteopathic therapy
0539 = Osteopathic services-other
0540 = Ambulance-general classification
0541 = Ambulance-supplies
0542 = Ambulance-medical transport
0543 = Ambulance-heart mobile
0544 = Ambulance-oxygen
0545 = Ambulance-air ambulance
0546 = Ambulance-neo-natal ambulance
0547 = Ambulance-pharmacy
0548 = Ambulance-telephone transmission EKG
0549 = Ambulance-other
0550 = Skilled nursing-general classification
0551 = Skilled nursing-visit charge
0552 = Skilled nursing-hourly charge
0559 = Skilled nursing-other

0560 = Medical social services-general classification
0561 = Medical social services-visit charge
0562 = Medical social services-hourly charges
0569 = Medical social services-other
0570 = Home health aid (home health)-general
classification
0571 = Home health aid (home health)-visit charge
0572 = Home health aid (home health)-hourly charge
0579 = Home health aid (home health)-other
0580 = Other visits (home health)-general
classification (under HHPPS, not allowed
as covered charges)
0581 = Other visits (home health)-visit charge
(under HHPPS, not allowed as covered charges)
0582 = Other visits (home health)-hourly charge
(under HHPPS, not allowed as covered charges)
0589 = Other visits (home health)-other
(under HHPPS, not allowed as covered charges)
0590 = Units of service (home health)-general
classification (under HHPPS, not allowed
as covered charges)
0599 = Units of service (home health)-other

1 REV_CNTR_TB Revenue Center Table

(under HHPPS, not allowed as covered charges)
0600 = Oxygen-general classification
0601 = Oxygen-stat or port equip/supply or count
0602 = Oxygen-stat/equip/under 1 LPM
0603 = Oxygen-stat/equip/over 4 LPM
0604 = Oxygen-stat/equip/portable add-on
0610 = Magnetic resonance technology (MRT)-general
classification
0611 = MRT/MRI-brain (including brainstem)
0612 = MRT/MRI-spinal cord (including spine)
0614 = MRT/MRI-other
0615 = MRT/MRA-Head and Neck
0616 = MRT/MRA-Lower Extremities
0618 = MRT/MRA-other
0619 = MRT/Other MRI
0621 = Medical/surgical supplies-incident to radiology-
subject to the payment limit - extension of 027X
0622 = Medical/surgical supplies-incident to other
diagnostic service-subject to the payment limit -
extension of 027X
0623 = Medical/surgical supplies-surgical dressings
(eff 1/95) - extension of 027X
0624 = Medical/surgical supplies-medical investigational
devices and procedures with FDA approved IDE's
(eff 10/96) - extension of 027X
0630 = Drugs requiring specific identification-general
classification
0631 = Drugs requiring specific identification-single drug
source (eff 9/93)
0632 = Drugs requiring specific identification-multiple drug
source (eff 9/93)
0633 = Drugs requiring specific identification-restrictive
prescription (eff 9/93)

0634 = Drugs requiring specific identification-EPO under 10,000 units
0635 = Drugs requiring specific identification-EPO 10,000 units or more
0636 = Drugs requiring specific identification-detailed coding (eff 3/92)
0637 = Self-administered drugs administered in an emergency situation - not requiring detailed coding
0640 = Home IV therapy-general classification (eff 10/94)
0641 = Home IV therapy-nonroutine nursing (eff 10/94)
0642 = Home IV therapy-IV site care, central line (eff 10/94)
0643 = Home IV therapy-IV start/change peripheral line (eff 10/94)
0644 = Home IV therapy-nonroutine nursing, peripheral line (eff 10/94)
0645 = Home IV therapy-train patient/caregiver, central line (eff 10/94)
0646 = Home IV therapy-train disabled patient, central line (eff 10/94)
0647 = Home IV therapy-train patient/caregiver, peripheral line (eff 10/94)
0648 = Home IV therapy-train disabled patient, peripheral line (eff 10/94)
0649 = Home IV therapy-other IV therapy services (eff 10/94)
0650 = Hospice services-general classification
0651 = Hospice services-routine home care
0652 = Hospice services-continuous home care-1/2
0655 = Hospice services-inpatient care
0656 = Hospice services-general inpatient care (non-respite)
0657 = Hospice services-physician services
0659 = Hospice services-other
0660 = Respite care (HHA)-general classification (eff 9/93)
0661 = Respite care (HHA)-hourly charge/skilled nursing (eff 9/93)
0662 = Respite care (HHA)-hourly charge/home health aide/homemaker (eff 9/93)
0670 = OP special residence charges - general classification
0671 = OP special residence charges - hospital based
0672 = OP special residence charges - contracted
0679 = OP special residence charges - other special residence charges
0700 = Cast room-general classification
0709 = Cast room-other
0710 = Recovery room-general classification
0719 = Recovery room-other
0720 = Labor room/delivery-general classification
0721 = Labor room/delivery-labor

0722 = Labor room/delivery-delivery
0723 = Labor room/delivery-circumcision
0724 = Labor room/delivery-birthing center
0729 = Labor room/delivery-other
0730 = EKG/ECG-general classification
0731 = EKG/ECG-Holter moniter
0732 = EKG/ECG-telemetry (include fetal monitering until 9/93)
0739 = EKG/ECG-other
0740 = EEG-general classification
0749 = EEG (electroencephalogram)-other
0750 = Gastro-intestinal services-general classification
0759 = Gastro-intestinal services-other
0760 = Treatment or observation room-general classification
0761 = Treatment or observation room-treatment room (eff 9/93)
0762 = Treatment or observation room-observation room (eff 9/93)
0769 = Treatment or observation room-other
0770 = Preventative care services-general classification (eff 10/94)
0771 = Preventative care services-vaccine administration (eff 10/94)
0779 = Preventative care services-other (eff 10/94)
0780 = Telemedicine - general classification (eff 10/97)
0789 = Telemedicine - telemedicine (eff 10/97)

0790 = Lithotripsy-general classification
0799 = Lithotripsy-other
0800 = Inpatient renal dialysis-general classification
0801 = Inpatient renal dialysis-inpatient hemodialysis
0802 = Inpatient renal dialysis-inpatient peritoneal (non-CAPD)
0803 = Inpatient renal dialysis-inpatient CAPD
0804 = Inpatient renal dialysis-inpatient CCPD
0809 = Inpatient renal dialysis-other inpatient dialysis
0810 = Organ acquisition-general classification
0811 = Organ acquisition-living donor (eff 10/94); prior to 10/94, defined as living donor kidney
0812 = Organ acquisition-cadaver donor (eff 10/94); prior to 10/94, defined as cadaver donor kidney
0813 = Organ acquisition-unknown donor (eff 10/94) prior to 10/94, defined as unknown donor kidney
0814 = Organ acquisition - unsuccessful organ search-donor bank charges (eff 10/94); prior to 10/94, defined as other kidney acquisition
0815 = Organ acquisition-cadaver donor-heart (obsolete, eff 10/94)
0816 = Organ acquisition-other heart acquisition (obsolete, eff 10/94)
0817 = Organ acquisition-donor-liver (obsolete, eff 10/94)
0819 = Organ acquisition-other donor (eff 10/94); prior to 10/94, defined as other

0820 = Hemodialysis OP or home dialysis-general
classification
0821 = Hemodialysis OP or home dialysis-hemodialysis-
composite or other rate
0822 = Hemodialysis OP or home dialysis-home supplies
0823 = Hemodialysis OP or home dialysis-home equipment
0824 = Hemodialysis OP or home dialysis-maintenance/100%
0825 = Hemodialysis OP or home dialysis-support services
0829 = Hemodialysis OP or home dialysis-other
0830 = Peritoneal dialysis OP or home-general
classification
0831 = Peritoneal dialysis OP or home-peritoneal-
composite or other rate
0832 = Peritoneal dialysis OP or home-home supplies
0833 = Peritoneal dialysis OP or home-home equipment
0834 = Peritoneal dialysis OP or home-maintenance/100%
0835 = Peritoneal dialysis OP or home-support services
0839 = Peritoneal dialysis OP or home-other
0840 = CAPD outpatient-general classification
0841 = CAPD outpatient-CAPD/composite or other rate
0842 = CAPD outpatient-home supplies
0843 = CAPD outpatient-home equipment
0844 = CAPD outpatient-maintenance/100%
0845 = CAPD outpatient-support services
0849 = CAPD outpatient-other
0850 = CCPD outpatient-general classification
0851 = CCPD outpatient-CCPD/composite or other rate
0852 = CCPD outpatient-home supplies
0853 = CCPD outpatient-home equipment
0854 = CCPD outpatient-maintenance/100%
0855 = CCPD outpatient-support services

0859 = CCPD outpatient-other
0880 = Miscellaneous dialysis-general classification
0881 = Miscellaneous dialysis-ultrafiltration
0882 = Miscellaneous dialysis-home dialysis aide visit
(eff 9/93)
0889 = Miscellaneous dialysis-other
0890 = Other donor bank-general classification; changed to
reserved for national assignment (eff 4/94)
0891 = Other donor bank-bone; changed to
reserved for national assignment (eff 4/94)
0892 = Other donor bank-organ (other than kidney); changed
to reserved for national assignment (eff 4/94)
0893 = Other donor bank-skin; changed to
reserved for national assignment (eff 4/94)
0899 = Other donor bank-other; changed to
reserved for national assignment (eff 4/94)
0900 = Psychiatric/psychological treatments-general
classification
0901 = Psychiatric/psychological treatments-electroshock
treatment
0902 = Psychiatric/psychological treatments-milieu
therapy
0903 = Psychiatric/psychological treatments-play
therapy

0904 = Psychiatric/psychological treatments-activity therapy (eff 4/94)
0909 = Psychiatric/psychological treatments-other
0910 = Psychiatric/psychological services-general classification
0911 = Psychiatric/psychological services-rehabilitation
0912 = Psychiatric/psychological services-day care-redefined 10/97 to less Intensive
0913 = Psychiatric/psychological services-night care redefined 10/97 to Intensive
0914 = Psychiatric/psychological services-individual therapy
0915 = Psychiatric/psychological services-group therapy
0916 = Psychiatric/psychological services-family therapy
0917 = Psychiatric/psychological services-biofeedback
0918 = Psychiatric/psychological services-testing
0919 = Psychiatric/psychological services-other
0920 = Other diagnostic services-general classification
0921 = Other diagnostic services-peripheral vascular lab
0922 = Other diagnostic services-electromyelogram
0923 = Other diagnostic services-pap smear
0924 = Other diagnostic services-allergy test
0925 = Other diagnostic services-pregnancy test
0929 = Other diagnostic services-other
0940 = Other therapeutic services-general classification
0941 = Other therapeutic services-recreational therapy
0942 = Other therapeutic services-education/training (include diabetes diet training)
0943 = Other therapeutic services-cardiac rehabilitation
0944 = Other therapeutic services-drug rehabilitation
0945 = Other therapeutic services-alcohol rehabilitation
0946 = Other therapeutic services-routine complex medical equipment

0947 = Other therapeutic services-ancillary complex medical equipment (eff 3/92)
0949 = Other therapeutic services-other
0951 = Professional Fees-athletic training
0952 = Professional Fees-kinesiotherapy
0960 = Professional fees-general classification
0961 = Professional fees-psychiatric
0962 = Professional fees-ophthalmology
0963 = Professional fees-anesthesiologist (MD)
0964 = Professional fees-anesthetist (CRNA)
0969 = Professional fees-other
0971 = Professional fees-laboratory
0972 = Professional fees-radiology diagnostic
0973 = Professional fees-radiology therapeutic
0974 = Professional fees-nuclear medicine
0975 = Professional fees-operating room
0976 = Professional fees-respiratory therapy
0977 = Professional fees-physical therapy
0978 = Professional fees-occupational therapy
0979 = Professional fees-speech pathology
0981 = Professional fees-emergency room

0982 = Professional fees-outpatient services
0983 = Professional fees-clinic
0984 = Professional fees-medical social services
0985 = Professional fees-EKG
0986 = Professional fees-EEG
0987 = Professional fees-hospital visit
0988 = Professional fees-consultation
0989 = Professional fees-private duty nurse
0990 = Patient convenience items-general classification
0991 = Patient convenience items-cafeteria/guest tray
0992 = Patient convenience items-private linen service
0993 = Patient convenience items-telephone/telegraph
0994 = Patient convenience items-tv/radio
0995 = Patient convenience items-nonpatient room rentals
0996 = Patient convenience items-late discharge charge
0997 = Patient convenience items-admission kits
0998 = Patient convenience items-beauty shop/barber
0999 = Patient convenience items-other

NOTE: Following Revenue Codes reported
for NHCMQ (RUGS) demo claims effective
2/96.

9000 = RUGS-no MDS assessment available
9001 = Reduced physical functions-
RUGS PA1/ADL index of 4-5
9002 = Reduced physical functions-
RUGS PA2/ADL index of 4-5
9003 = Reduced physical functions-
RUGS PB1/ADL index of 6-8
9004 = Reduced physical functions-
RUGS PB2/ADL index of 6-8
9005 = Reduced physical functions-
RUGS PC1/ADL index of 9-10
9006 = Reduced physical functions-
RUGS PC2/ADL index of 9-10
9007 = Reduced physical functions-

RUGS PD1/ADL index of 11-15
9008 = Reduced physical functions-
RUGS PD2/ADL index of 11-15
9009 = Reduced physical functions-
RUGS PE1/ADL index of 16-18
9010 = Reduced physical functions-
RUGS PE2/ADL index of 16-18
9011 = Behavior only problems-
RUGS BA1/ADL index of 4-5
9012 = Behavior only problems-
RUGS BA2/ADL index of 4-5
9013 = Behavior only problems-
RUGS BB1/ADL index of 6-10
9014 = Behavior only problems-
RUGS BB2/ADL index of 6-10
9015 = Impaired cognition-
RUGS IA1/ADL index of 4-5
9016 = Impaired cognition-

RUGS IA2/ADL index of 4-5
9017 = Impaired cognition-
RUGS IB1/ADL index of 6-10
9018 = Impaired cognition-
RUGS IB2/ADL index of 6-10
9019 = Clinically complex-
RUGS CA1/ADL index of 4-5
9020 = Clinically complex-
RUGS CA2/ADL index of 4-5d
9021 = Clinically complex-
RUGS CB1/ADL index of 6-10
9022 = Clinically complex-
RUGS CB2/ADL index of 6-10d
9023 = Clinically complex-
RUGS CC1/ADL index of 11-16
9024 = Clinically complex-
RUGS CC2/ADL index of 11-16d
9025 = Clinically complex-
RUGS CD1/ADL index of 17-18
9026 = Clinically complex-
RUGS CD2/ADL index of 17-18d
9027 = Special care-
RUGS SSA/ADL index of 7-13
9028 = Special care-
RUGS SSB/ADL index of 14-16
9029 = Special care-
RUGS SSC/ADL index of 17-18
9030 = Extensive services-
RUGS SE1/1 procedure
9031 = Extensive services-
RUGS SE2/2 procedures
9032 = Extensive services-
RUGS SE3/3 procedures
9033 = Low rehabilitation-
RUGS RLA/ADL index of 4-11
9034 = Low rehabilitation-
RUGS RLB/ADL index of 12-18
9035 = Medium rehabilitation-
RUGS RMA/ADL index of 4-7
9036 = Medium rehabilitation-

RUGS RMB/ADL index of 8-15
9037 = Medium rehabilitation-
RUGS RMC/ADL index of 16-18
9038 = High rehabilitation-
RUGS RHA/ADL index of 4-7
9039 = High rehabilitation-
RUGS RHB/ADL index of 8-11
9040 = High rehabilitation-
RUGS RHC/ADL index of 12-14
9041 = High rehabilitation-
RUGS RHD/ADL index of 15-18
9042 = Very high rehabilitation-
RUGS RVA/ADL index of 4-7
9043 = Very high rehabilitation-
RUGS RVB/ADL index of 8-13

9044 = Very high rehabilitation-
RUGS RVC/ADL index of 14-18

Changes effective for providers entering
RUGS Demo Phase III as of 1/1/97 or later

9019 = Clinically complex-
RUGS CA1/ADL index of 11
9020 = Clinically complex-
RUGS CA2/ADL index of 11D
9021 = Clinically complex-
RUGS CB1/ADL index of 12-16
9022 = Clinically complex-
RUGS CB2/ADL index of 12-16D
9023 = Clinically complex-
RUGS CC1/ADL index of 17-18
9024 = Clinically complex-
RUGS CC2/ADL index of 17-18D
9025 = Special care-
RUGS SSA/ADL index of 14
9026 = Special care-
RUGS SSB/ADL index of 15-16
9027 = Special care-
RUGS SSC/ADL index of 17-18
9028 = Extensive services-
RUGS SE1/ADL index 7-18/1 procedure
9029 = Extensive services-
RUGS SE2/ADL index 7-18/2 procedures
9030 = Extensive services-
RUGS SE3/ADL index 7-18/3 procedures
9031 = Low rehabilitation-
RUGS RLA/ADL index of 4-13
9032 = Low rehabilitation-
RUGS RLB/ADL index of 14-18
9033 = Medium rehabilitation-
RUGS RMA/ADL index of 4-7
9034 = Medium rehabilitation-
RUGS RMB/ADL index of 8-14
9035 = Medium rehabilitation-
RUGS RMC/ADL index of 15-18
9036 = High rehabilitation-
RUGS RHA/ADL index of 4-7
9037 = High rehabilitation-

---------- ----------

RUGS RHB/ADL index of 8-12
9038 = High rehabilitation-
RUGS RHC/ADL index of 13-18
9039 = Very High rehabilitation-
RUGS RVA/ADL index of 4-8
9040 = Very high rehabilitation-
RUGS RVB/ADL index of 9-15
9041 = Very high rehabilitation-
RUGS RVC/ADL index of 16
9042 = Very high rehabilitation-
RUGS RUA/ADL index of 4-8
9043 = Very high rehabilitation-

RUGS RUB/ADL index of 9-15
9044 = Ultra high rehabilitation-
RUGS RUC/ADL index of 16-18